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PROGRAM POLICY

Prior Authorization

Prior authorization is not usually required for most Denti-Cal benefits. The following is a list of Denti-Cal procedures that require prior authorization:

Code	Procedure
035	Hospital Care (non-emergency)
049-050	Prophylaxis - if more than once in a six month period
061-062	Prophylaxis including topical application of fluoride if more than once in a six month period
301	Conscious sedation if over 13 years with handicap
450-499	All periodontal services except 451 (emergency), 453, 472 and 473
511-513	Root canal therapy
530, 531	
551-598	Orthodontia
600-648	Restorative for patients in hospitals, convalescent homes and nursing homes
650-663	Crowns
680-682	Fixed Bridge Pontics
692-693	
700-716	Removable Prosthodontics
722-724	
750-763	Denture repair if more than 2 in 12 months
950-998	Maxillofacial services
999	Non-emergency unlisted procedures

Dental services provided to patients in hospitals, skilled nursing facilities, and intermediate care facilities are covered under the Medi-Cal Dental Program only following prior authorization of each non-emergency and non-diagnostic dental service (Section 51307(f)(3), Title 22, California Code of Regulations). Emergency services may be performed on convalescent patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. However, the provider must submit clinical information with the claim describing the patient's condition and the reason the emergency services were necessary.

The California Medi-Cal Dental Program (Denti-Cal) within the State Department of Health Services, and Title 22, California Code of Regulations (CCR), Section 51455, state that prior authorization may be required of any or all providers for any or all covered benefits of the program except those services specifically exempted by Section 51056, (a) and (b). These prior authorization requirements do not change when the patient has other coverage; you should submit for prior authorization and indicate the primary carrier. **No verbal authorization will be granted by Denti-Cal. Denti-Cal reserves the right to require prior authorization in accordance with these guidelines.**

Special Prior Authorization Review

As part of our ongoing Quality Review and Evaluation program, Denti-Cal may require selected providers to obtain prior authorization for some or all services, except those exempted by Title 22. The providers may be selected at random or on any other reasonable basis. Written notification will be sent to the selected providers at least 30 days in advance of the prior authorization requirement. The prior authorization requirement may be waived in selected cases where the existing medical condition of the patient makes it impossible to obtain adequate preoperative diagnosis, clinically and/or radiographically. A statement of the medical condition that prevents a complete preoperative examination, and the need for dental treatment, must be submitted with the Treatment Authorization Request (TAR). Denti-Cal reserves the right of approval in these cases and may request additional information to substantiate the TAR.

Election of Prior Authorization

Prior authorization is not necessary for the majority of procedures. If a provider chooses to submit a TAR for services that do not normally require prior authorization, Denti-Cal may not review these procedures. However, these services may be reviewed if they are submitted as part of a total treatment plan. When a provider receives a Notice of Authorization (NOA) for procedures that were submitted on a TAR but do not normally require prior authorization, the NOA is not a guarantee that those procedures have been reviewed and approved.

If a provider elects to have any proposed treatment plan prior authorized, all provisions relating to prior authorization for all services listed apply as follows:

- The services must be performed during the valid authorization period.
- Failure of the patient to appear for a second scheduled pre-treatment screening examination may result in the denial of requested services.
- To be considered for full payment, NOAs must be received by Denti-Cal within six months after the end of the month in which the final service is performed. NOAs will be considered for payment at 75 percent of the SMA amount when they are received within nine months after the end of the month in which the final service was performed. NOAs will be considered for payment at 50 percent of the SMA amount when they are received within one year after the end of the month in which the final service was performed.
- Patient must be eligible during the month in which procedure is actually performed.

Clinical Screening

During the processing of the TAR, Denti-Cal may decide to screen the patient for clinical evaluation purposes. If this occurs, the dental office and the patient will be notified of the screening appointment with a Clinical Screening Dentist. To ensure attendance, it would be helpful for the dental office to remind the patient of the examination.

Non-Transfer of Prior Authorization

Prior authorization is not transferable from one provider to another. If for some reason the provider who received authorization is unable to complete the service, another provider cannot perform the service until a new treatment plan is authorized under his/her own provider number.

To expedite processing of a TAR with a change of provider, submit a new TAR with an attached statement from the patient indicating a change of provider.

Retroactive Prior Authorization

Title 22, Section 51003, State of California Code of Regulations (CCR) allows for the retroactive approval of prior authorization under the following conditions:

- When certification of eligibility was delayed by the county social services office;
- When "other coverage" denied payment of a claim for services;
- When the required service could not be delayed;
- When a patient does not identify himself/herself to the provider as a Medi-Cal beneficiary through deliberate concealment or because of physical or mental incapacity to identify himself/herself. The provider must submit in writing that concealment occurred, and the submission of the TAR must be within 60 days of the date the provider certifies he/she was made aware of the patient's eligibility.

Medi-Cal Capitated Health Care Plan Authorization Requirements

Prior authorization is required for any medical services necessary when providing dental services to beneficiaries covered under Medi-Cal contracted capitated health care plans.

Certain Medi-Cal beneficiaries are eligible for medical services through capitated health care plans rather than directly through the fee-for-service Medi-Cal program. These beneficiaries can be identified by a special enrollment card issued by their particular plan. They are also issued a Medi-Cal Identification Card which contains a printed message limiting their eligibility to certain medical and dental services excluded by their capitated coverage. Benefi-

ciaries who have a capitated health care plan which covers dental services are not issued a Medi-Cal card.

If non-emergency services are necessary in conjunction with dental services provided for a capitated health care plan enrollee, the dentist must obtain prior authorization for the medical services from the health care plan. Typically, such medical services take the form of in-patient hospital admission or prescriptions for post-dental care.

In medical emergencies, where the required services cannot be delayed and the health care plan cannot be contacted in advance, prior authorization is not required. However, the dentist must contact the health care plan as soon as possible and must fully document the emergency when billing the plan for the services provided.

Capitated health care plans include Primary Case Care Management (PCCM) contractors, county-wide health systems (such as Health Plan of San Mateo and Santa Barbara Health Initiative), the Redwood Health Foundations (covering beneficiaries in Sonoma, Lake and Mendocino counties), and most Prepaid Health Care Plans (PHPs) which furnish coverage for their enrollees and assume the cost of most medical services provided for them. Most of these plans exclude dental benefits. In that case, covered dental procedures may be billed to Denti-Cal.

To contact a particular capitated health care plan, refer to the information given on the beneficiary's enrollment/identification card or consult your telephone directory. You may also telephone the Department of Health Services Office of Medi-Cal Dental Services at (916) 464-3888 for assistance.

$1,800 Limit per Calendar Year for Beneficiary Dental Services

$1,800 Limit per Calendar Year

The California Department of Health Services has implemented changes in covered benefits set forth as follows: The fiscal year (FY) 2005-2006 Budget Act requires the California Department of Health Services to employ changes in covered benefits as set forth in Assembly Bill 131 (Chapter 80, Statutes of 2005). Assembly Bill 131 amends Section 14080 of the Welfare and Institutions Code by limiting non-exempt dental services for beneficiaries 21 years of age or older to $1,800 per beneficiary for each calendar year beginning January 1, 2006 and lasting through January 1, 2009.

Providers are responsible to check the beneficiary cap status prior to rendering services to determine the current remaining balance. This information can be accessed by telephoning Denti-Cal toll-free at (800) 423-0507.

To help reduce the possibility that procedures performed will not be fully paid because the dental cap has been reached, providers should

- verify the beneficiary cap.
- discuss with beneficiary any other treatment recently received from another provider.
- quickly submit claims for procedures not requiring prior authorization.
- upon receipt of a Notice of Authorization (NOA), promptly perform services and submit requests for payment.

Providers are reminded that approval of a Treatment Authorization Request (TAR) does not guarantee payment. Debits toward the cap are based upon the order in which claims and NOAs are processed. Non-exempt services will be paid in the order they are received and processed until the annual cap is reached for a calendar year. Payments will not be applied towards the $1,800 per calendar year limit for 1) Long Term Care; 2) pregnancy-related procedures; 3) services related to emergency treatment; and 4) exempt procedures.

This limitation shall not apply to any of the following:

1) Emergency dental services.
2) Services that are federally mandated, including pregnancy-related services.
3) Dentures.
4) Maxillofacial and complex oral surgery.
5) Maxillofacial services, including dental implants and implant-retained prostheses.

6) Services provided in long-term care facilities.

Emergency Dental Services

The following procedure codes may be exempt from the limitation if they are related to an adequately documented emergency service: 020, 030, 035, 040, 080, 110, 111, 113, 114, 115, 116, 117, 118, 125, 150, 160, 200, 201, 202, 203, 204, 220, 230, 231, 232, 259, 260, 261, 262, 263, 264, 265, 266, 269, 270, 271, 273, 276, 277, 278, 279, 280, 281, 282, 290, 292, 300, 301, 400, 451, 501, 502, 503, 685, 686, 687, 690, 694, 695, 696, 716, 720, 721, 723, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 900, 901, 902, 903, 904, 905, 906, 907, 913, 915, and 916.

Pregnancy-Related Services

Pregnant beneficiaries will be excluded from the limitation, *when pregnancy-related procedure codes are requested along with a pregnancy-related aid code*. The exempt aid codes for pregnancy-related services are as follows: 0U, 0V, 2Y, 3T, 3V, 44, 48, 55, 58, 5F, 5J, 5R, 5T, 5W, 5Y, 6U, 7C, 7G, 7K, 7N, and 8T. Descriptions of these and other aid codes may be found beginning on Page 2-63 of this Provider Manual.

The exempt procedure codes for pregnancy-related services are as follows: 010, 015, 049, 050, 062, 452, 453, 472, 473, and 474. Descriptions of these and other procedure codes may be found beginning on Page 4-15 of this Provider Manual.

Dentures

The following prosthetic procedure codes will always be exempt from this limitation: 700, 701, 702, 703, 704, 705, 706, 708, 709, 712, 716, 720, 721, 722, 723, 724. Descriptions of these and other procedure codes may be found beginning on Page 4-15 of this Provider Manual.

Maxillofacial & Surgical Dental Procedures

The following maxillofacial and surgical dental procedure codes will always be exempt from the limitation: 299, 960, 962, 964, 966, 968, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 985, 998, and 999. Descriptions of these and other procedure codes may be found beginning on Page 4-15 of this Provider Manual.

Long-Term Care

Beneficiaries will be excluded from this limitation if they have Long Term Care (LTC) aid codes *or* reside in either Place of Service 4/SNF (Skilled Nursing Facility) or Place of Service 5/ICF (Intermediate Care Facility). Exempt long term aid codes include 13, 23, 53, and 63. Descriptions of these and other aid codes may be found beginning on Page 2-63 of this Provider Manual.

All other aid codes and procedure codes will be subject to the $1,800 calendar year limitation.

The Interactive Voice Response (IVR) System will be upgraded to provide an automated response to current dental limitation amounts.

Limited Dental Benefits for Pregnant Women and Clarification of the Scope of Benefits and Submission of Claims for Emergency/Pregnancy-Related Procedures

Limited Dental Benefits for Pregnant Women

On October 7, 2005, the Governor signed into law Senate Bill (SB) 377, directing the Department of Health Services to immediately provide coverage of certain non-emergency dental benefits (described below) for pregnant Medi-Cal beneficiaries. Prior to October 7, 2005, these benefits were only available to pregnant women in the following restricted aid codes: 44, 48, 5F, and 58. Beginning October 7, 2005, these same benefits are available for pregnant women in the following 16 *additional* aid codes: 0U, 0V, 3T, 3V, 5J, 5R, 5T, 5W, 5Y, 55, 6U, 7C, 7G, 7K, 7N, and 8T.

Acceptable procedure codes now available to these beneficiaries include 010, 015, 049, 050, 062, 452, 453, 472, 473, 474.

The following policy will be applied for all claims submitted for the procedures indicated above: If the patient is pregnant and is Aid Code 0U, 0V, 3T, 3V, 44, 48, 5F, 5J, 5R, 5T, 5W, 5Y, 55, 58, 6U, 7C, 7G, 7K, 7N, or 8T, indicate *"PREGNANT"* in the "Comments" area (Box 34).

Please note that Treatment Authorization Requests (TARs) are not allowed and may not be submitted for these aid codes. If a

TAR is submitted for any of the procedures described for these aid codes, it will be denied – not because the beneficiary is ineligible for the procedure, but because the procedure is already authorized for beneficiaries in these aid codes and there is no TAR process for procedures for these beneficiaries.

For claims requesting Procedures 472 and 473, either a history of Procedure 452 must be on file or the provider must submit documentation explaining why Procedure 452 was not performed prior to these procedures. ***Please note: Prior authorization is not allowed nor are radiographs required for these procedures.*** However, for Procedures 452, 472, 473 and 474 a complete periodontal chart must be submitted with the claim.

Pregnant women in the above-listed aid codes are also eligible to receive emergency dental services. For claims for emergency services, a clinical emergency certification statement and, when applicable, radiographs and/or other documentation to justify the procedure must be submitted. **Simply stating "Pregnant" for emergency procedures is insufficient and the claim will be denied.**

The following procedures are allowable as emergency dental procedures for the above-listed pregnancy aid codes: 020, 030, 035, 040, 080, 110, 111, 113, 114, 115, 116, 117, 118, 125, 150, 160, 200, 201, 202, 203, 204, 220, 230, 231, 232, 259, 260, 261, 262, 263, 264, 265, 266, 269, 270, 271, 273, 276, 277, 278, 279, 280, 281, 282, 290, 292, 299, 300, 301, 400, 451, 501, 502, 503, 511, 512, 513, 530, 531, 600, 601, 602, 603, 611, 612, 613, 614, 640, 641, 645, 646, 648, 670, 671, 672, 685, 686, 687, 690, 694, 695, 696, 716, 720, 721, 723, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 900, 901, 902, 903, 904, 905, 906, 907, 913, 915, 916

Providers are also reminded that emergency root canal procedures are *only* allowed if the tooth is totally avulsed or there is a fracture of a coronal portion of a permanent tooth, exposing the vital pulpal tissue.

When the procedures listed above are provided for patients in one of the above aid codes (regardless of whether they are pregnant), an emergency certification statement is always required. This statement must be either entered in the "Comments" area (Box 34) on the claim form or attached to the claim. It must:

(a) Describe the nature of the emergency, including clinical information pertinent to the patient's condition; and

(b) Explain why the emergency services provided were considered immediately necessary.

The statement must be signed by the dentist providing the services (in the "Comments" area or on the attached statement) and must provide enough information to show the existence of an emergency dental condition and need for immediate treatment. **Merely stating an emergency existed or that the patient was in pain is insufficient**. When applicable, necessary documentation and/or radiographs to justify the procedure must be submitted with the claim.

Payment Policies

Payment made by Denti-Cal in accordance with the guidelines of the California Medi-Cal Dental Program must be accepted by the provider as payment in full for covered services. It is a violation of state and federal regulations to charge a Medi-Cal beneficiary any additional fee for covered dental services.

Denti-Cal will only pay for the lowest cost procedure that will correct the dental problem. For example, Denti-Cal cannot allow a porcelain crown when a restoration would correct the dental problem. A dental office cannot charge Denti-Cal more than it charges a private patient for the services performed. The dental office should list its usual and customary fee when filling out the claim, TAR or NOA.

For tax purposes, Denti-Cal uses Form 1099 to report earnings to the Internal Revenue Service (IRS) for each billing provider who has received payment from Denti-Cal during the year. Federal law requires that Denti-Cal mail 1099 forms by January 31 of each year to reflect earnings from January 1 through December 31 of the previous year.

It is the provider's responsibility to make certain that Denti-Cal has the correct billing provider name, address and taxpayer identifi-

cation number (TIN) or Social Security number (SSN) that correspond exactly to the information the IRS has on file. If this information does not correspond exactly, Denti-Cal is required by law to apply a 31 percent withholding to all future payments made to the billing provider. To verify how your tax information is registered with the IRS, please refer to the preprinted label on IRS Form 941, "Employer's Quarterly Federal Tax Return," or any other IRS-certified document. You may also contact the IRS to verify how your business name and TIN or SSN are recorded.

If you do not receive your 1099 form, or if your tax or earnings information is incorrect, please contact Denti-Cal at (800) 423-0507 for the appropriate procedures for reissuing a correct 1099 form.

Assistant Surgeons

Assistant surgeons should bill Denti-Cal using Procedure 299 (Unlisted Surgical Service or Procedure), and may be paid 20% of the surgical fee paid to the primary surgeon (dentist or physician) provided the following is submitted with the claim:

- ✓ The operating report containing the name of the assistant surgeon;
- ✓ Proof of payment to the primary surgeon.

Surgical fees include major maxillofacial and orthognathic procedures, as well as trauma surgery, and include all associated extractions. All other procedures (anesthesia, radiographs, restorations, et cetera) performed on the same date of service as the surgical procedure including bedside visits (Procedure 030) and hospital care (Procedure 035) are not considered in the determinations of the surgical fee and are not payable to assistant surgeons.

Assistant surgeons will be paid 20% of the primary surgeon's allowable surgery fee.

Time Limitations for Billing

Time limitations for billing services provided under the California Medi-Cal Dental Program are governed by Section 14115 of the Welfare and Institutions Code. Denti-Cal must receive a claim no later than six calendar months after the end of the month in which the service was performed to consider the claim for full payment (100 percent of the SMA). Claims received within six to nine months after the end of the month in which the service was performed will be considered for payment at 75 percent of the SMA amount. Claims received ten to twelve months after the end of the month in which the service was performed will be considered for payment at 50 percent of the SMA amount. The time limitation for billing will be applied to each date of service.

Denti-Cal may receive and process late claims upon review of substantiating documentation that justifies the late submittal of a claim. The following is a list of reasons delayed submissions are acceptable when circumstances are beyond the control of the provider:

1. A patient did not identify himself/herself to a provider as a Medi-Cal beneficiary at the time services were performed. The provider must submit the claim for payment within 60 days after the date certified by the provider that the patient first did identify himself/herself as a Medi-Cal beneficiary. The date so certified on the claim must be no later than one year after the month in which services were performed.
2. The maximum time period for submission of a claim involving other coverage is one year from the date of service, to allow sufficient time for the provider to obtain proof of payment or non-liability of the other insurance carrier.
3. If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, Denti-Cal may extend the period of submission for one year from the date of service. Title 22, Section 51008, lists those specific circumstances which would be considered beyond the control of the provider and under which such an extension may be granted:
   - ♦ delay or error in the certification or determination of Medi-Cal eligibility by the State or county;
   - ♦ delay in delivering a completed removable appliance when a patient does not return in a timely manner for delivery (Section 51470(b) states an undelivered, custom-made prosthesis must be retained for no less than one year after the date it was ordered, and is payable at 80% of the amount after

the provider has attempted to deliver the prosthesis to the patient);

- ♦ damage to or destruction of provider's business office or records by natural disaster, including fire, flood, or earthquake; or circumstances involving such a disaster that have substantially interfered with the timely processing of bills;
- ♦ delay of required authorization by Denti-Cal or California Children Services;
- ♦ delay by Denti-Cal in supplying billing forms to the provider;
- ♦ theft, sabotage, or other deliberate, willful acts by an employee;
- ♦ other circumstances, clearly beyond the control of the provider that have been reported to the appropriate law enforcement or fire agency, where applicable;
- ♦ special circumstances, such as court or fair hearing decisions.

Interim Payment

Interim payments are made to Denti-Cal providers for unpaid claims that have been delayed at least 30 days due to Denti-Cal or State errors, or for paid claims affected by retroactive changes.

A provider may contact Denti-Cal, either by telephone or in writing, to request interim payment. Denti-Cal will determine if a claim qualifies for interim payment. If it does not qualify, or if a determination cannot be made, Denti-Cal must notify the provider by telephone within 24 hours, followed by a written notice within two workdays. If Denti-Cal determines that a claim does qualify for interim payment, the findings are forwarded to the State for final approval or denial of the request.

When the State reaches a final decision, it will notify Denti-Cal.

Denti-Cal, in turn, will notify the provider. Once final approval of interim payment has been received from the State by Denti-Cal, the payment request is processed and a check is generated and sent to the provider.

The following pages contain the Manual of Criteria for Medi-Cal Authorization (Dental Services).

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MANUAL OF CRITERIA
FOR
MEDI-CAL AUTHORIZATION
(DENTAL SERVICES)

SEPTEMBER 2000

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
MEDI-CAL POLICY DIVISION
1501 CAPITOL AVENUE, BUILDING 171
SACRAMENTO, CA 95814

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REGULATORY/STATUTORY AUTHORITY

This “Manual of Criteria for Medi-Cal Authorization (Dental Services)” is incorporated, by reference, into the state regulations governing the Medi-Cal program in Title 22, California Code of Regulations (CCR), Section 51003.

Section 51003, in turn, implements various provisions of state law; specifically, Sections 14053, 14132, 14133, 14133.1, 14133.25, and 14133.3 of the Welfare and Institutions (W&I) Code. The Department of Health Services has enacted Section 51003 under the authority granted by the Legislature in Sections 14105 and 14124.5 and 10725 of the W&I Code and Section 57(c) of Chapter 328 of the Statutes of 1982.

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Introduction

This document is a compilation of criteria which apply to dental services under the Medi-Cal program. It is designed to provide assistance to dentists treating Medi-Cal beneficiaries and to dental consultants in determining service authorization and payment under the authority and subject to the provisions of the Welfare and Institutions (W & I) Code and the California Code of Regulations (CCR).

This document sets forth program benefits and clearly defines limitations, exclusions, and special documentation requirements. These criteria are designed to ensure that program funds are spent on services that are medically necessary and are in substantial compliance with regulations under Title 22, California Code of Regulations (CCR).

The criteria published in this manual, while not exhausting the range of possibilities or combinations of circumstances, will nonetheless help to standardize the provider's and consultant's exercise of professional judgment. If the clinical condition of the patient reflects the criteria required by this manual and such information is fully documented by the provider, the consultant may grant approval if in his/her professional judgment the service request is reasonable and consistent with the dental needs of the patient and conforms to the intent of the program.

Without sufficient acceptable diagnostic information, the consultant has no option but to deny approval or defer a decision. The necessity for the consultant to obtain adequate information and, thereby, to make a judgment on dental necessity is an integral part of the prior authorization and payment process.

While the manual contains prior authorization and payment information, this manual is not an instruction guide in the proper completion of prior authorization or payment requests.

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Statement of Department of Health Services' (DHS') Intent

These criteria are intended to:

1. Assist Medi-Cal dental consultant's review of prior authorization and payment requests.

2. Promote uniform and consistent review of prior authorization and payment requests.

3. Assist providers in requesting authorization and payment and documenting the need for such services or items.

4. Improve the quality of care and cost efficiency of dental services given to patients.

5. Avoid provision of unnecessary or excessive items or services to patients.

6. Promote objectivity and uniformity in appropriate treatment of dental conditions.

7. Ensure that only the lowest cost item or service, covered by the program, that meets the patients needs is authorized.

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VISITS - DIAGNOSTIC (010 - 099)

Procedure 010
Complete Examination, Initial Episode of Treatment Only

1. A benefit once per patient per dentist for the initial examination when the claim form indicates a complete examination was rendered
2. Not a benefit when provided on the same day of service with Procedure 020, 030, 080, 220, 451, 720, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, or 763.

Procedure 015
Examination Periodic (Annual)

1. A benefit:
   a. Once in a six-month period after six months have elapsed following provisions of Procedure 010 by the same provider.
2. Not a benefit when provided on the same day of service with Procedure 020, 030, 080, 220, 451, 720, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, or 763.

Procedure 020
Office Visit During Regular Office Hours, for Treatment and/or Observation of Teeth or Supporting Structures

1. A benefit if documentation of need for the following is provided:
   a. Postoperative service where need is shown to be beyond normal follow-up care, or
   b. Postoperative service where primary service was performed by another office, or
   c. Observation and/or minimal treatment of injuries, pain, and/or infection.
2. Not a benefit in conjunction with Procedure 030.
3. Not a benefit when specific services other than diagnostic radiographs are provided on the same day of service.

Procedure 030
Professional Visit After Regular Office Hours or to Bedside

1. A benefit for office visits, visits to beneficiary's house or other facility before or after regular office hours (8:00 a.m. to 7:00 p.m.) or on Saturdays, Sundays, and holidays when visit necessitates provider's return to the office in response to requests received outside of regular office hours to provide emergency services as defined in Title 22, Section 51056. Time and date of call and visit must be noted to be considered for payment.
2. Multiple after-hour returns to office in a 24-hour period are a benefit when documented to be necessary.
3. A benefit for bedside visits once per single address per day, regardless of the number of patients seen. The need for each visit must be specifically described in order to be considered for payment.
4. Not payable for preoperative visits or normal uncomplicated follow-up care included in global fee for therapeutic service.
5. Payable in addition to service provided.
6. A benefit only in conjunction with covered dental services.

Procedure 035
Hospital Care

1. A benefit when prior authorized, when justified by a treatment plan or billed as an emergency service where the emergency is verified and documented according to Section 51056 of Title 22, California Code of Regulations (CCR), but it is the responsibility of the provider to specify the actual operating time on the treatment form.
2. Except in emergency care, a copy of the approved Authorization for Hospitalization form must accompany the treatment form when submitted for payment. This procedure may be prior authorized without the hospitalization form, but there must be adequate documentation describing the need or reason for hospitalization.
3. Emergency and nonemergency hospitalization must be documented by a copy of

the operating room (OR) report or hospital discharge summary.

4. This procedure may be authorized without any specific time designation as there is usually no method by which the provider can designate preoperatively the number of hours required.
5. Payable for each hour or fraction thereof only for time spent in operating suite as documented on operative report.
6. Not payable for time spent compiling patient history, time involved writing reports, or for postoperative or follow-up visits.

Assistants - When a provider bills as an assistant surgeon, a copy of the primary surgeon's billing must be requested if it is not attached (regardless of whether the principal surgeon is an M.D. or D.D.S.). When the need is justified, the fee of an assistant dentist or physician will be paid at 20 percent of the primary surgeon's allowable surgery fee as listed on the Schedule of Maximum Allowances (SMA) or Relative Value Study (RVS). Bedside visits (030) and hospital care (035) are not payable to assistant surgeons.

Procedure 040
Specialist Consultation

1. A consultation for diagnostic purposes is a benefit to dental providers who are recognized in any of the dental specialties providing:
   a. The specialist is not the dentist providing the treatment, and
   b. A copy of the specialist's report accompanies the claim.
2. This procedure is not a benefit for normal referrals from one practitioner to another for continued treatment by a specialist.

DENTAL SEALANTS (045 - 046)
General Policies

1. Dental sealants, as defined by the Medi-Cal Dental Program, are a dental procedure designed for the prevention of pit and fissure caries in teeth that are free of nonincipient decay and restorations on the tooth surface(s) to be sealed for permanent first molars of beneficiaries to age twenty-one (21) and permanent second molars of beneficiaries to age twenty-one (21).
2. Dental sealants are payable only when applied for the prevention of caries in pits and fissures on the buccal, lingual, or occlusal surfaces of permanent first and second molars.
3. Dental sealants are payable once per tooth within 36 months of their application and only when the tooth surfaces that are sealed are free of nonincipient caries and restorations on the tooth surface(s) to be sealed.
4. The fee for dental sealants includes replacement or repair by the original provider for 36 months.
5. Dental sealants do not require prior authorization under procedure codes 045 and 046. These procedures will be authorized without the submission of x-rays or other documentation requirements.
6. Dental sealants may be applied by a licensed dentist or auxiliary personnel who are authorized to apply sealants under the Dental Practice Act.

Procedure 045
Pit and Fissure Dental Sealants for Permanent First Molars, Beneficiaries to Age Twenty-One (21)

A benefit:

1. For beneficiaries to age twenty-one (21);
2. For each permanent first molar (teeth #s 3-14-19-30) not more frequently than once every 36 months

Payable:

1. Once per tooth within 36 months of application.
2. Payment includes replacement or repair by the original provider for 36 months.
3. This procedure will be authorized without the submission of x-rays or other documentation requirements.

Procedure 046
Pit and Fissure Dental Sealants for Permanent Second Molars, Beneficiaries to Age Twenty-One (21)

A benefit:

1. For beneficiaries to age twenty-one (21);
2. For each permanent second molar (teeth #s 2-15-18-31) not more frequently than once every 36 months.

Payable:

1. Once per tooth within 36 months of application.
2. Payment includes replacement or repair by the original provider for 36 months.
3. This procedure will be authorized without the submission of x-rays or other documentation requirements.

ORAL PROPHYLAXIS (049-062)
General Policies

Oral prophylaxis means the preventive dental procedure of scaling and polishing, which includes complete removal of calculus, soft deposits, plaque, stains, and smoothing of unattached tooth surfaces. The object of the treatment is the creation of an environment in which hard and soft tissues can be maintained in good health by the patient. Subgingival curettage (Procedure 452) is covered only as a periodontal surgical service related to periodontal care. Prophylaxis, Procedures 049 and 050, and Topical Application of Fluoride including Prophylaxis, Procedures 061 and 062, are benefits:

1. Once in a six-month period without prior authorization.
2. More frequently than once in a six-month period if physical limitation or oral conditions (e.g., drug hyperplasia) exist, provided:
   a. The service is prior authorized, and
   b. The request for authorization includes documentation of the physical limitation or oral condition justifying need.
3. More than one prophylaxis in a six-month period may be subject to preoperative clinical examination (See Appendix, Section 1).

Procedure 049
Prophylaxis, Beneficiaries Through Age 12

Procedure 050
Prophylaxis, Beneficiaries 13 Years of Age and Over

Procedure 061
Prophylaxis, Including Topical Application of Fluoride, Beneficiaries Age 5 and Under

Procedure 062
Prophylaxis, Including Topical Application of Fluoride, Beneficiaries Ages 6 through 17 Years of Age

Procedure 080
Emergency Treatment, Palliative

1. A benefit when an emergency exists, provided:
   a. The claim is accompanied by an emergency justification statement, and
   b. The claim shows the specific treatment performed (i.e., tooth letter or number, temporary filling, opened canal for drainage, soft tissue treatment, etc.), and
   c. It is not a service which is described by Procedure 020, 220, 451, or 720.
2. Payable by visit regardless of service(s) provided.

RADIOGRAPHS AND PHOTOGRAPHS (110-125)
General Policies

1. Radiographs are covered when taken in compliance with state and federal regulations for radiation hygiene.
2. According to accepted standards of dental practice, the lowest number of radiographs

needed to provide the diagnosis should be taken.

3. The quality of panographic-type radiographs shall be considered insufficient for diagnosis in periodontics, endodontics, and operative dentistry.

4. Pursuant to Title 22, CCR, Section 51051, dental x-ray laboratories, per se, shall not be considered providers under the Medi-Cal program.

5. Procedures 116 and 117 are not benefits for edentulous areas.

6. Supplementary bitewing radiographs are a benefit not more than once every six months. Single radiographs are a benefit when necessary and commensurate with the signs and symptoms exhibited by the patient. A maximum of 11 radiographs are allowable as follows:

   a. Procedure 110 plus 10 of Procedure 111; or

   b. Procedure 110 plus Procedure 118 plus 9 of Procedure 111; or

   c. Procedure 116 plus 9 of Procedure 111; or

   d. Procedure 117 plus 7 of Procedure 111

7. Xeroradiographs are a benefit at the same scope and level of coverage provided for radiographs.

8. If radiographs are not submitted with the treatment form for procedures requiring radiographs because the beneficiary or parent refused to have radiographs taken, a statement to this effect must be included in order to determine scope and level of benefits.

9. When radiographs are required as a condition of payment for a procedure and radiographs are medically contraindicated, narrative documentation shall include a statement of the medical contraindication. Diagnostic dental radiographs are medically contraindicated when additional exposure to ionizing radiation would complicate or be detrimental to a patient's existing medical or physical condition. Examples are, but not limited to, the following:

   a. The first trimester of pregnancy.

   b. Recent application of therapeutic doses of ionizing radiation to the head and neck areas.

   c. Hypoplastic or aplastic anemics.

   d. When a patient's inability to respond to commands or directions would necessitate sedation or anesthesia in order to accomplish the radiographic procedures.

   e. Other medical conditions precluding the use of ionizing radiation in the oral and maxillofacial area which are justified in writing by the patient's attending physician.

Procedure 110
Intraoral Periapical, Single, First Radiograph

Procedure 111
Intraoral Periapical, Each Additional Radiograph

1. Additional film is a benefit to a maximum of ten radiographs in a treatment series.

Procedure 112
Intraoral, Complete Series

1. A complete series is a benefit once per patient in a 36-month period.

2. A complete series shall be:

   a. 14 periapical radiographs plus bitewings, or

   b. Panographic radiograph plus bitewings, or

   c. Panographic radiograph plus periapical radiographs.

Procedure 113
Intraoral, Occlusal Radiograph

Procedure 114
Extraoral, Single, Head or Lateral Jaw

Procedure 115
Extraoral, Each Additional Head or Lateral Jaw

Procedure 116
Bitewings, Two Radiographs
Not a benefit for edentulous area.

Procedure 117
Bitewings, Four Radiographs
Not a benefit for edentulous area.

Procedure 118
Bitewings, Anterior, One Radiograph

Procedure 119
Photograph or Slide, First

Procedure 120
Photograph or Slide, Each Additional (Maximum Five)

Procedure 125
Panographic-Film, Single Radiograph

1. Panographic radiographs alone, when appropriate to the diagnosis in orthodontic care, oral or maxillofacial surgical procedures, or extractions in multiple quadrants (two or more), shall be benefits only once in a 36-month period, except when documented as essential for follow-up or post-operative care in a treatment series.
2. Panographic radiographs shall be insufficient for diagnosis in periodontics, endodontics, and restorative dentistry.
3. Not a benefit on the same day of service as Procedure 112 (Intraoral, Complete Series).

BIOPSY AND PATHOLOGY REPORTS (150-199)

Procedure 150
Biopsy of Oral Tissue

1. A benefit as an independent procedure for collecting tissue specimen(s).
2. Not a benefit in conjunction with the extraction of a tooth or root or excision of any body part or neoplasm in the same area or region on the same day.

Procedure 160
Gross and Microscopic Histopathologic Examination

A benefit when the pathology report is submitted from a certified local pathology laboratory.

ORAL SURGERY (200-299)
General Policies

1. Diagnostic periapical radiographs are required for all surgical procedures that are submitted for authorization and/or payment except:
   a. For procedures performed on soft tissue structures;
   b. When payment is requested for only one (1) or two (2) simple extractions;
   c. For Procedure 250 (Alveoplasty on an edentulous quadrant.)

   If radiographs are not sufficient to justify a need, i.e., for soft tissue procedures, additional diagnostic material (photographs or models) and/or a statement of justification must be presented.
2. Submitted periapical radiographs must show all aspects of a suspected pathologic area or neoplasm, and the entire crown and apices of all teeth to be excised or extracted. In those cases where the radiograph of the crown of the tooth is not complete but there is sufficient evidence presented to substantiate the need for the surgical procedure, the surgical procedure may be allowed.
3. Oral surgery services to correct longstanding abnormalities of the mandible or maxilla, e.g., prognathia or retrognathia, or

skin grafts for denture retention purposes or interosseous implants for procedures other than the treatment of fractures may be benefits under the maxillofacial-orthodontic program subject to prior authorization.

4. Extraction of asymptomatic teeth is not a benefit. The following includes, but is not all inclusive of, conditions which may be considered symptomatic when documented:

   a. Fully bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length.

   b. Teeth which are involved with a cyst, tumor, or other neoplasm.

   c. Unerupted teeth which are distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth.

   d. The extraction of all remaining teeth in preparation for a full prosthesis, but only when authorized.

   e. Malaligned tooth (teeth) which causes intermittent gingival inflammation.

   f. Extractions of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous tooth (teeth).

   g. Perceptible radiologic pathology that fails to elicit symptoms.

   h. Extractions that are required to complete medically necessary orthodontic dental services.

5. Nonemergency hospitalization for dental services may be authorized only where there is a medical need and the services cannot be performed in an outpatient setting.

6. Routine postoperative visits (within 30 days following surgical procedure) are considered part of, and included in, the global fee for the surgical procedure.

7. Extractions of asymptomatic deciduous teeth that appear by radiographic evaluation ready to exfoliate naturally are not a benefit.

8. By-report procedures may be used by the provider to modify payment levels when he has encountered unforeseen complications which are not usually considered normal to the particular procedure listed.

Procedure 200
Removal of Erupted Tooth, Uncomplicated, First Tooth

1. A benefit for the uncomplicated removal of the first tooth (deciduous or permanent) in a treatment series. The extraction of the first tooth (200) is payable once per provider per treatment series.

2. A benefit for the removal of any tooth by the closed method or forceps only technique where the mucoperiosteum is not detached.

Procedure 201
Removal of Erupted Tooth (Teeth), Uncomplicated, Each Additional Tooth

1. A benefit for the uncomplicated removal of any tooth, beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series. Multiple uncomplicated extractions of adjacent teeth include the use of mucoperiosteal flaps and routine alveoplasty procedures when needed.

2. A benefit for the removal of a tooth by the closed method or forceps only technique where the mucoperiosteum is not detached.

Procedure 202
Removal of Erupted Tooth, Surgical

1. A benefit when removal of any erupted tooth requires:

   a. The retraction of a mucoperiosteal flap, and

   b. The removal of substantial alveolar bone in order to effect the extraction. Examples include, when documented, but are not limited to:

(1) Crown undermined by caries which prohibits normal forceps technique;

(2) Divergent, thin, curved, or brittle roots which require separate and individual manipulation or extraction;

(3) Hypercementosis; and

(4) Partial ankylosis.

Procedure 203
Removal of Root or Root Tip Completely Covered by Bone

1. A benefit for removal of root or root tip where:

   a. The root or root tip is enclosed by bone, and

   b. Exposure of the major portion or all of the root by removal of alveolar bone is necessary to effect extraction.

2. Not payable to the provider receiving payment for the tooth extraction.

Procedure 204
Removal of Root or Root Tip Not Totally Covered by Bone

1. A benefit for removal of residual root or root tip not totally covered by bone.

2. Not payable to provider receiving payment for the tooth extraction.

Procedure 220
Postoperative Visit, Complications, e.g., Osteitis

1. Payable to the provider of the original operative service when:

   a. Postoperative complications are present and described, and

   b. The service is provided more than 30 days after the surgical procedure.

2. Payable to a provider, other than the provider performing the operative service, for treatment of complications arising from a surgical procedure.

General Policies –
Removal of Impacted Tooth
(Procedures 230-232)

1. The level of payment for extraction of an impacted permanent tooth shall be based on the degree or amount of the crown of the tooth which is covered by tissue as evidenced by the diagnostic radiographs.

2. The procedure number shall be adjusted to agree with the severity of impaction as evidenced by the diagnostic radiographs unless otherwise modified by report.

Procedure 230
Removal of Impacted Tooth, Soft Tissue

1. A benefit if a permanent tooth is removed by the open method and:

   a. The major portion or all of the crown of the tooth was covered by mucogingival tissue, and

   b. The major portion or all of the crown of the tooth was not covered by alveolar bone.

Procedure 231
Removal of Impacted Tooth, Partial Bony

1. A benefit if removal of alveolar bone to expose any portion of the crown of the permanent tooth is necessary to effect extraction by the open method.

Procedure 232
Removal of Impacted Tooth, Complete Bony

1. A benefit if removal of alveolar bone to expose the major portion of the crown of the permanent tooth is necessary to effect extraction by the open method.

General Policies –
Alveoloplasty/Vestibuloplasty
(Procedures 250-256)

1. Alveolectomy (alveoloplasty) is a collective term for the operation by which the shape and condition of the alveolar process is

improved for preservation of the residual bone.

2. Tuberosity reductions are considered to be included as part of the global fee for an alveoloplasty or multiple extractions in the same quadrant.

3. Some form of alveolectomy is indicated in almost every case of multiple extractions and frequently in single extractions as well. Normally alveolectomy procedures necessary in conjunction with the extraction of teeth are included as part of the extraction procedures.

Procedure 250
Alveoloplasty Per Quadrant, Edentulous

1. A benefit if performed to:
   a. Correct surgical or anatomical deformities, or
   b. Developmental or pathological abnormalities, and
   c. The service is not generally part of the normal extraction process.
2. Not a benefit within six months following extraction of teeth in same quadrant.

Procedure 252
Alveoloplasty Per Quadrant, In Conjunction With Extractions

1. A benefit for alveolectomy as a separate procedure to be performed in conjunction with multiple extractions when the provider documents the fact that an unusual condition exists.

   Example:

   a. irregular alveolar process due to massive bone loss from periodontal involvement.
   b. Large bony prominences surrounding one or two remaining teeth.
   c. Irregular alveolar process resulting from intermittent extractions.

Procedure 255
Vestibuloplasty, Submucosal Resection (Not to Include Grafts)

Procedure 256
Alveoloplasty With Ridge Extension, Secondary Epithelialization (Per Arch)

1. A benefit if an increase in the effective use of a prosthetic appliance through the modification of alveolar bone, mucogingival tissue, fibrous tissue, and/or muscle attachments can be expected.
2. Normal postoperative care and any necessary splints required within a 30-day period following surgery are included in the fee for the procedure.
3. Procedures of less than a full arch will be prorated according to the extent of the surgical procedure.

Procedure 257
Removal of Palatal Exostosis (Torus)

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring at the midline of the hard palate.
2. Not a benefit if the condition is:
   a. Asymptomatic, or
   b. Will be bypassed by a dental prosthesis.
3. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required.

Procedure 258
Removal of Mandibular Exostosis (Torus) Per Quadrant

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal

bone occurring on the lingual aspect of the mandible.

2. Not a benefit if the condition is:
   a. Asymptomatic, or
   b. Will be bypassed by a dental prosthesis.
3. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required.

Procedure 259
Excision of Hyperplastic Tissue, Per Arch

1. A benefit when:
   a. Inflammatory hyperplastic tissue interferes with normal mastication, or
   b. In an edentulous case, where the inflammatory hyperplastic tissue interferes with normal use or function of a prosthetic appliance.
2. This procedure usually relates to treatment of inflammatory hyperplasia in the buccal vestibule caused by denture irritation. It is not a benefit for:
   a. Drug hyperplasia, or
   b. Where removal requires extensive gingival contouring.

Procedure 260
Incision and Drainage of Abscess, Intraoral

1. A benefit as an independent intraoral procedure for the prompt and efficient evacuation of a dentoalveolar, subperiosteal, or gingival abscess which is determined to be the initial site of the infection.
2. Not a benefit when performed in conjunction with an apicoectomy, pulpotomy, pulpectomy, root canal treatment, excision of a foreign body, or extraction.

Procedure 261
Incision and Drainage of Abscess, Extraoral

1. A benefit as an independent extraoral procedure for the prompt and efficient evacuation of a dentoalveolar, subperiosteal, or gingival abscess which is determined to be the initial site of infection and cannot be relieved through an intraoral procedure.
2. Not a benefit when performed in conjunction with an apicoectomy, pulpotomy, pulpectomy, root canal treatment, excision of a foreign body, or extraction.

Procedure 262
Excision Pericoronal Gingiva (Operculectomy)

1. A benefit if the removal of gingival tissue partly covering the crown or occlusal surface of an erupting tooth is necessary to:
   a. Alleviate masticatory trauma of opposing tooth, or
   b. Prevent recurrence of intermittent infection, or
   c. Alleviate delayed eruption.
2. Not a benefit if there is insufficient arch length to accept the exposed permanent tooth into normal alignment.
3. Not a benefit when performed in conjunction with a pulpotomy, root canal treatment, crown preparation, or extraction of the same tooth.

Procedure 263
Sialolithotomy, Intraoral

1. A benefit for the removal of a salivary stone from salivary gland or duct utilizing an intraoral approach.
2. The nature, extent, and location of stone must be documented by x-rays, other diagnostic material, or by report to be processed for payment.

Procedure 264
Sialolithotomy, Extraoral

1. A benefit for the removal of a salivary stone from salivary gland or duct utilizing an extraoral approach.

2. The nature, extent, and location of stone must be documented by x-rays, other diagnostic material, or by report to be processed for payment.

Procedure 265
Closure of Salivary Fistula

1. A benefit for the surgical closure or transplantation of a salivary fistula dislocated by surgical or accidental trauma or infection.
2. Etiology as well as a surgical report is required in order to process for payment.

Procedure 266
Dilation of Salivary Duct

1. A benefit if all of the following conditions exist:
    a. Normal flow of saliva is prevented.
    b. The presence of a salivary stone has been ruled out.
    c. Stricture or scar formation is present.
    d. Dilation is nonsurgical.
    e. Etiology and operative reports accompany the claim.
2. Not a benefit in conjunction with a sialolithotomy.

Procedure 267
Reduction of Tuberosity, Unilateral

1. A benefit if the edentulous tuberosities interfere with:
    a. Normal mastication, or
    b. Proper use, fitting, or retention of a new prosthetic device, or
    c. Reconstruction or reline of an existing prosthetic appliance.
2. Not a benefit in the same quadrant with an alveolectomy, a second or third molar extraction, an alveoloplasty, or an alveoloplasty with ridge extension.

General Policies –
Excision of Benign Tumor
(Procedures 269-270)

1. Payment shall not be processed without a diagnostic radiograph of the neoplasm in question or other diagnostic material confirming need for excision.
2. The appropriate procedure number shall be determined by measurement of the tumor image on the diagnostic radiograph presented unless otherwise documented by report.
3. Claims for additional fee because of extent or severity of the procedure must be justified by report.
4. A benefit only as separate procedure, not in conjunction with an extraction, apicoectomy, tuberosity reduction, or excision of any body part.
5. Not a benefit on same service date as a biopsy of tissue in same area or region.

Procedure 269
Excision of Benign Tumor, Up to 1.25 cm

Procedure 270
Excision of Benign Tumor, Larger Than 1.25 cm

Procedure 271
Excision of Malignant Tumor

1. Payment shall not be processed without a diagnostic radiograph or descriptive narration in operative report and other diagnostic material confirming need for excision.
2. Pricing to be determined by identifying procedure listed in the California RVS and multiplying by the unit value developed for the Medi-Cal program. When procedure is not listed in RVS, closest similar procedure shall be used to develop allowable fee.
3. In the absence of a laboratory report, or where the laboratory report fails to confirm malignancy, allowable fee will be determined by payment of comparable benign lesion.

Procedure 273
Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Permanent Teeth and/or Alveolus

1. A benefit for the closed reduction of alveolar process fracture with stabilization.
2. A benefit for reimplantation and/or stabilization of accidentally evulsed permanent anterior teeth.

Procedure 275
Transplantation of Tooth or Tooth Bud

1. A benefit only if:
   a. The beneficiary is under 18 years of age, and
   b. Where autogenous third molar to first or second molar area transplants are made to replace single molar that is missing or is in an unrestorable condition.
2. Not a benefit where the beneficiary is especially susceptible to caries, exhibits unhealthy gingivae or is in poor general health.

Procedure 276
Removal of Foreign Body From Bone (Independent Procedure)

1. A benefit as an independent procedure only to remove any reaction-producing foreign body completely covered by bone.
2. Not a benefit where a foreign body is excised in conjunction with removal of tumor, cyst, or other body part.

Procedure 277
Radical Resection of Bone for Tumor With Bone Graft

1. A benefit for radical resection of tissue with concomitant autogenous grafts.
2. Payment level determined by SMA or operative report using the California RVS to determine unit value of surgery accomplished.

Procedure 278
Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body

1. A benefit for radical antrum operation to remove tooth fragments or foreign body.
2. Not a benefit when tooth, tooth fragment, or other foreign matter is retrieved through a tooth socket.
3. An operative report is required for payment processing to determine extent of surgical procedure.

Procedure 279
Oral Antral Fistula Closure

1. A benefit for the plastic closure of fistulas as an independent procedure, provided a statement describing the etiology as well as surgical report is included with the claim.

General Policies – Excision of Cyst (Procedures 280-281)

1. The appropriate procedure number shall be determined by the measurement of the cystic image on the diagnostic x-ray presented unless otherwise documented by report.
2. Payment will not be made without an adequate radiograph of the neoplasm in question.
3. Biopsy (150) on same day for same area is not a covered service.
4. Postoperative care within a 30-day period following surgery shall be included in the fee for the services.

Procedure 280
Excision of Cyst up to 1.25 cm

Procedure 281
Excision of Cyst over 1.25 cm

Procedure 282
Sequestrectomy

1. A benefit for the surgical removal of devitalized portions of bone that have become separated, all or in part, from contiguous bone.
2. Claims for additional fee because of extent or severity of the procedure must be justified by report.
3. Diagnostic x-rays fully depicting area of subject sequestrum are required for payment processing.

Procedure 285
Condylectomy of Mandible, Unilateral

1. A benefit for the excision of the condyle in cases such as traumatic arthritis, malunion of fracture, or rheumatoid arthritis.
2. Diagnostic x-rays fully depicting involved joint and other diagnostic material necessary to justify the need for the procedure must be submitted for payment processing.

Procedure 289
Meniscectomy of Temporomandibular Joint, Unilateral

1. A benefit for excision of the meniscus to correct internal disturbances of the joint due to changes in the meniscus.
2. Diagnostic x-rays fully depicting involved joint and other diagnostic material necessary to justify the need for the procedure must be submitted for payment processing.

Procedure 290
Excision of Foreign Body, Soft Tissue

1. A benefit to excise any reaction producing foreign body from soft tissue.
2. Diagnostic x-rays and/or other diagnostic materials must be submitted to justify need for procedure.
3. Not payable when done in conjunction with the excision of a tumor, cyst, or other body part.
4. Not a benefit on same date when biopsy (No. 150) billed in same area or region.

Procedure 291
Frenectomy or Frenotomy, Separate Procedure

1. A benefit where it is documented that:
   a. A short labial frenum interferes with the mobility of the central portion of the lip.
   b. A hypertrophy of the frenum and papilla palatina interferes with the proper fitting and retention of a prosthetic appliance.
   c. A hyperthrophy of the frenum and overextension to the papilla.

Procedures 292
Suture of Soft Tissue Wound or Injury

1. A benefit to suture any soft tissue wound or injury occurring accidentally.

Procedure 294
Injection of Sclerosing Agent into Temporomandibular Joint

1. A benefit for relief of recurrent and habitual dislocation of the temporomandibular joint and subluxation with clicking, provided differential diagnostic material justifying the need for the procedure is submitted with the claim.

Procedure 295
Injection of Trigeminal Nerve Branches for Destruction

1. A benefit for the treatment of idiopathic trifacial neuralgia, provided:
   a. Conservative treatment methodologies have failed, and
   b. Differential diagnostic material justifying the need for the procedure and describing the prior treatment which has failed is submitted with the claim.

General Policies – Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption (Procedures 296-298)

1. A benefit only when sufficient arch length is available to accept the exposed permanent tooth.
2. Degree of tissue or bone impaction will be determined by evaluation of diagnostic x-rays submitted unless otherwise documented by report.

Procedure 296
Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption, Soft Tissue

1. A benefit in those cases where the major portion of all of the crown of the tooth is covered by mucogingival tissue.

Procedure 297
Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption, Partial Bony

1. A benefit in those cases where it is necessary to expose any portion of the crown of the tooth by removal of alveolar bone.

Procedure 298
Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption, Complete Bony

1. A benefit in those cases where it is necessary to expose the major portion or all of the crown of the tooth by removal of alveolar bone.

Procedure 299
Unlisted Surgical Service or Procedure

1. When an unlisted service or procedure is provided, it must be substantiated by report.
2. The report must provide an adequate definition or description of the services or procedure (e.g., operative or narrative report), using the following as indicated:
   a. Diagnosis (postoperative),
   b. Size, location, and number of lesions or procedures where appropriate,
   c. Major surgical procedure and supplementary procedure(s),
   d. Whenever possible, list the nearest similar procedure according to the Schedule of Maximum Allowances (SMA) or Relative Value Studies (RVS),
   e. Estimated follow-up, and
   f. Operative time.
3. The requested fee must be listed and is subject to review.

DRUGS AND ANESTHESIA (300-449)

Procedure 300
Therapeutic Drug Injection

1. A benefit for injectable therapeutic drugs.
2. Not a benefit:
   a. For self-administered drugs dispensed by the dentist for beneficiary's use, or
   b. When administered as an analgesic or sedative in conjunction with conscious sedation, relative analgesia, or nitrous oxide.

Procedure 301
Conscious Sedation, Relative Analgesia (Nitrous Oxide), Per Visit

1. A benefit:
   a. Without prior authorization required for beneficiaries through age 12 or a resident of a DHS-certified intermediate care facility (ICF) who is developmentally disabled. The need for its use must be justified and documented.
   b. With prior authorization for beneficiaries 13 years of age or older when it is justified and documented that a mental or physical handicap precludes a rational response to commands.
2. Not a benefit:
   a. To alleviate patient apprehension, nervousness, or fear.

b. When diagnostic procedures are only services provided.

3. Injectable premedication is payable when reasonable and necessary with local anesthetic and justified by report.

Procedure 400
General Anesthesia

1. Explanation

   General Anesthesia, as used for dental pain control, means the elimination of all sensation accompanied by a state of unconsciousness. The use of general anesthesia is a benefit of the program without prior authorization required, provided the need for its use is documented and justified.

2. Office (outpatient) general anesthesia may be payable when the provider indicates on the claim form an acceptable reason why local anesthesia is contraindicated. Such reasons may include, but not be limited to:

   a. Severe mental retardation.

   b. Spastic type handicap.

   c. Prolonged (more than 30 minutes) or severe surgical procedures.

   d. Acute infection at an injection site.

   e. Failure of a local anesthetic in control of pain.

   f. An actual contraindication to a local anesthetic agent. (Contraindication to local anesthetic does not have to be indicated by a physician. A provider's statement that such a condition exists may be acceptable. An indication on a claim form why a surgical procedure failed under local anesthesia may be sufficient justification for payment processing.)

3. Payment for anesthesia will be denied if no documentation is listed on the claim form.

4. Intravenous (IV) or intramuscular (IM) sedation where complete unconsciousness does not occur is not payable as Procedure 400.

5. If all surgical procedures are denied for any reason, Procedure 400 will also be denied.

6. A benefit in conjunction with the removal of fixed arch bars, wire splints, and metal implants when removal is accomplished by a provider other than the primary provider.

PERIODONTICS (450-499)
General Policies – Periodontics
(Procedures 450-499)

1. Periodontal service benefits, with the exception of emergency treatment (451), shall be limited to beneficiaries 18 years of age and older. Periodontal surgical benefits, shall be extended to any individual when drug-induced gingival hyperplasia is documented, regardless of age.

2. Periodontal care shall be limited to those patients:

   a. Who exhibit generalized periodontal pocket depths in excess of the 4-5mm range,

   b. Who have a minimum of 4 isolated pockets over 5mm in depth, and

   c. Where the isolated pockets of more than 5mm in depth have failed to respond to conservative treatment, including emergency treatment of periodontal abscesses.

3. Subgingival curettage, in the generally accepted sense, is a surgical service involving removal of the epithelial lining, granulation tissue, and other pocket contents, and includes the planing of the root surface to remove deposits and smoothing of the root surfaces. It is performed for patients with generalized pocket depths within the range of more than 4-5mm and a minimum of 4 isolated pockets over 5mm in depth. This procedure is usually performed with local anesthesia.

4. Periodontal services shall be approved on an ordered schedule initially encompassing only the direct, least invasive measures. After subgingival curettage and root planing (Procedure 452) is performed and following a six to nine month evaluation

period, if the shrinkage of edematous gingiva and resolution of pockets to within 4mm or less has not been accomplished and the patient exhibits adequate motivation, the dentist may render subsequent periodontal procedures verified by periodontal charting. Payment for subsequent procedures shall not be made without adequate justification verified by the submission of the six to nine month postoperative periodontal charting.

5. In order to make a fair evaluation of prior authorization requests for Procedures 452 and 474, the following information shall be included with the request:

   a. Diagnostic periapical radiographs.

   b. Periodontal charting of pocket depths, bone loss, and mobility of all teeth, in addition to charting missing and to-be-extracted teeth.

   c. Description of case type patterns according to Current Procedural Terminology for Periodontists.

   d. Brief and reasonable case information and/or dental history.

6. Guidelines for Reviewing Periodontal Treatment.

   a. Procedure 452 (Subgingival Curettage and Root Planing) requires prior authorization and shall be performed prior to the provision of Procedure 472 (Gingivectomy or Gingivoplasty) or Procedure 473 (Osseous and Mucogingival surgery).

   b. Case Type I (shallow pockets, little or no bone loss). Case Type I is essentially gingivitis. Scaling and prophylaxis (050) shall be adequate to control these cases. Authorization for subgingival curettage (periodontal treatment) shall not be granted.

   c. Case Types II and III (moderate to deep pockets (4-5mm+), moderate to severe bone loss, unsatisfactory topography).

      The major emphasis of periodontal care covered under the Denti-Cal program shall be the treatment of Case Types II and III. Predicated on an ordered schedule of services, initial requests shall be limited to nonsurgical service (050) or the surgical service of subgingival curettage (452) for these cases. If it is determined, during the six- to nine-month evaluation period, that the patient fails to cooperate or to demonstrate vigorous interest in his/her oral health, no further periodontal services shall be approved or rendered.

   d. Case Type IV (deep pockets, severe bone loss, advanced mobility patterns). Case Type IV treatment plans shall not be authorized or rendered.

Procedure 451
Emergency Treatment (Periodontal Abscess, Acute Periodontitis, etc.)

1. A benefit to treat such conditions as a periodontal abscess and acute necrotizing ulcerative gingivitis. Treatment may include, but not limited to, superficial debridement, application of oxygenating drugs, selective supra- and subgingival scaling and curettage.

2. Payment shall not be made without adequate documentation and justification of need.

3. Emergency periodontal procedures are benefits only twice in a 12-month period. Additional periodontal procedures may be a benefit with documentation which justifies the need.

Procedure 452
Subgingival Curettage and Root Planing, Per Full Mouth Treatment

1. This procedure requires prior authorization and shall be authorized as a full mouth treatment visit, not by quadrant or arch. Multiples of this procedure shall be provided on different days to be payable.

2. When justified, a maximum of four full mouth treatments may be authorized in a one year period.

3. Not payable on the same day as 050.

4. This procedure shall be performed prior to the provision of Procedure 472 (Gingivectomy or Gingivoplasty) or Procedure 473 (Osseous and Mucogingival Surgery).

Procedure 453
Occlusal Adjustment (Limited) per Quadrant (Minor Spot Grinding)

1. A benefit when limited to the adjustment of the equivalent of one quadrant or less.
2. The quadrant shall be indicated on the request for payment.
3. Not payable in conjunction with completed prosthodontics, crowns, and bridge services, or multiple restorations involving occlusal surfaces.

Procedure 472
Gingivectomy or Gingivoplasty Per Quadrant

1. A benefit in the treatment of moderate to deep gingival pockets (4-5mm), moderate to severe bone loss, and tooth mobility which includes the removal of the soft tissue side of the pocket, eliminating the pocket, and creating a new gingival contour.
2. The quadrant shall be indicated on the request for payment.
3. Procedure 452 (Subgingival Curettage and Root Planing) shall have been performed prior to this procedure.
4. This procedure requires periodontal charting of the patients entire dentition following the six to nine month evaluation period post operative to Procedure 452.

Procedure 473
Osseous and Mucogingival Surgery Per Quadrant

1. A benefit for the surgical eradication of intrabony pockets and sufficient bone contouring to achieve adequate gingival architecture.
2. The quadrant shall be indicated on the request for payment.
3. Procedure 452 (Subgingival Curettage and Root Planing) shall have been performed prior to this procedure.
4. This procedure requires periodontal charting of the patient's entire dentition following the six to nine month evaluation period post operative to procedure 452.

Procedure 474
Gingivectomy or Gingivoplasty, Treatment Per Tooth (Fewer Than Six Teeth)

1. May be authorized when an isolated pocket(s) has not responded to conservative treatment.
2. May be authorized where a drug-induced hyperplasia has exacerbated in isolated areas.
3. This procedure is not payable as an emergency procedure and does require prior authorization.

ENDODONTICS (500-549)
General Policies – Endondontics (Procedures 500-549)

1. Includes those procedures which provide complete root canal filling on permanent teeth and pulpotomies (pulpectomies) on both deciduous and permanent teeth. Root canal therapy is covered if medically necessary. It is medically necessary when the tooth is nonvital (necrosis, gangrene, or death of the pulp), or the pulp has been compromised by caries, trauma or accident which may lead to the death of the pulp, and the criteria set forth in this Manual.
2. The prognosis of the affected tooth, other remaining teeth, and the type of restoration allowable will be evaluated in considering root canal therapy.
3. Authorization and payment for root canal treatment includes, but is not limited to, any of all of the following procedures:
   a. Any incision and drainage (Procedures 260 and 261) necessary in relation to the root canal therapy.
   b. Vitality test.

c. Radiographs required during treatment.

d. Culture

e. Medicated treatment.

f. Final filling of canal(s).

g. Final treatment radiographs(s).

4. Necessary retreatment and postoperative care within a 90-day period is included in the reimbursement fee.

5. Root canal therapy is not a benefit when extraction is appropriate for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

6. Root canal treatment must be completed prior to payment.

7. The date of service on the payment request should reflect the final treatment date.

8. Pulp capping, cement bases, and insulating liners are considered part of restorations and are included in the fee for the completed restoration(s).

9. Permanent restoration for an endodontically treated tooth is a benefit when need is justified and documented and:

   a. The payment requested is accompanied by a final treatment radiograph documenting satisfactory completion of the root canal treatment, and

   b. The coverage criteria specified in this Manual for the particular restoration are met.

Procedure 501
Therapeutic Pulpotomy

1. A benefit for primary teeth only.

2. A single procedure is payable for the total service regardless of the number of treatment stages.

3. Any acceptable and recognized method is a benefit where the procedure is justified and pulp extirpation is complete.

Procedure 502
Vital Pulpotomy

1. A benefit for vital permanent teeth only.

2. A single procedure is payable for the total service regardless of the number of treatment stages.

3. An acceptable and recognized method is a benefit where the procedure is justified and where the coronal portion of the pulp is removed.

Procedure 503
Recalcification, Includes Temporary Restoration, Per Tooth

1. Recalcification requires placing a temporary restoration on the permanent tooth involved for a reasonable length of time.

2. Not a benefit:

   a. When a permanent restoration is placed before recalcification is demonstrated, or

   b. For primary teeth, or

   c. When used as a base.

Procedure 511
Anterior Root Canal Therapy; and

Procedure 512
Bicuspid Root Canal Therapy; and

Procedure 513
Molar Root Canal Therapy

1. A benefit with prior authorization for any permanent tooth and subject to criteria for coverage set forth in this Manual.

2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth) and sufficient other radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are required for prior authorization of permanent root canal therapy.

3. Root canal therapy for permanent teeth is medically necessary and covered when

criteria set forth in (1) above and (a), (b) or (c) below are met.

a. The tooth is acting as a satisfactory abutment for an existing functional dental prosthesis or will act as such for a covered dental prosthesis, and the final post-treatment restoration of the treated tooth will afford acceptable retention longevity.

b. The final post-treatment restoration of the treated tooth will afford acceptable retention longevity, and

(1) Missing teeth do not jeopardize the integrity or masticatory function of the dental arches, and

(2) The tooth is opposed by a natural or artificial tooth, and

(3) The tooth is necessary to maintain adequate masticatory function, and

(4) Periodontal condition of the tooth and the remaining teeth must be no more involved than Periodontal Case Types II and III, as defined in General Policies -- Periodontics (Procedures 450-499), subsection 6.b.

c. Extraction of the tooth is not an acceptable alternative because it is established that preservation of the tooth is medically necessary (e.g., hemophiliac).

4. Root canal therapy may be performed as an emergency service, without prior authorization, under the following conditions: (The condition must be justified by documentation.)

a. Fracture of a coronal portion of a permanent tooth, exposing the vital pulpal tissue.

b. When a tooth has been accidentally evulsed, the root canal may be performed prior to replacement of the tooth in the socket. These two emergency situations must meet the arch integrity, tooth longevity, and all other criteria listed for Procedures 511-531.

5. Requests for payment for completed root canal therapy and/or apicoectomy must be accompanied by a final treatment radiograph.

6. Requests for authorization for payment of the final restoration of a tooth receiving root canal therapy cannot be acted upon until satisfactory completion of the root canal therapy is documented.

Procedure 530
Apicoectomy – Surgical Procedure in Conjunction With Root Canal Filling

1. Not a benefit for routine surgical endodontics where the periapical lesion is minimal or nonexistent, only a benefit if documentation supports the need for surgical intervention.

2. This procedure is indicated when an abnormality or blockage of the root end prevents the cleaning and sealing of the apical portion of a root canal through a coronal approach. This occurs most commonly when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, or when a canal wall has been perforated or "shelved" during canal enlargement.

3. Concurrent endodontic treatment and apicoectomy may be approved as an emergency procedure only if:

a. The claim is documented as to why the service was immediately necessary and the other requirements of Section 51056, Title 22, California Code of Regulations, are satisfied.

b. The tooth could not have been extracted and a replacement added to an existing or allowable partial denture.

c. The dentition in general is adequate or in good condition.

4. Any indicated retrograde restoration is included in the global fee.

Procedure 531
Apicoectomy (Separate Surgical Procedure) Per Tooth

1. This procedure is indicated when an abnormality or blockage of the root end prevents the cleaning and sealing of the apical portion of a root canal through a coronal approach and the tooth remains symptomatic. This occurs most commonly when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, and when a canal wall has been perforated or "shelved" during canal enlargement.
2. When Procedure 531 is submitted for prior authorization in conjunction with any root canal therapy (511, 512, 513), it will be combined to Procedure 530. When separate procedures (example: 511 and 531) have been prior authorized but they were completed on the same day by the same doctor, the two procedures will be combined to Procedure 530.
3. Any indicated retrograde restoration is included in the global fee.

Procedure 534
Apexification/Apexogenesis (Therapeutic Apical Closure, Per Treatment)

1. Apexification/Apexogenesis is defined as a technique for encouraging continued root formation and apical closure in teeth with incomplete apical development when the pulp is affected by trauma or caries.
2. The initial pulpotomy procedure may be repeated at six-month intervals after the initial episode with payment allowed for each treatment. Final obliteration of the root canal(s) may be accomplished when a radiograph indicates sufficient apical formation. At the time the definitive treatment is provided, the appropriate root canal therapy procedure is allowable. The criteria for authorizing root canal treatment also apply to apexification and must be present prior to the initial pulpotomy treatment.
3. Not a benefit when Procedure 534 and a completed root canal treatment are performed on the same tooth on the same day.

RESTORATIVE DENTISTRY (600-679)

General Policies – Restorative Services

1. Restorative services shall be benefits when, medically necessary and when carious activity has extended through the dentoenamel junction (DEJ).
2. When a claim is submitted listing procedures that must be verified by radiographic examination and no radiographs are attached, the procedures are not payable unless an acceptable reason why radiographs could not be obtained is stated on the claim. (Acceptable reasons shall be limited to those presented under Radiographs and Photographs (Procedure Codes 110-125), General Policies, Section 9 a-e).
3. The restoration of incipient, nonactive, or noncarious defects is not a benefit for adult beneficiaries.
4. All restored surfaces on a single tooth will be considered connected if performed on the same date. Payment may be made for a particular surface on a single tooth only once in each episode of treatment, irrespective of the number or combinations of restorations placed.
5. Prior authorization is not required, except for those patients in hospitals, convalescent homes, and nursing homes.
6. The program provides amalgam, silicate, plastic, composite restorations, or stainless steel crowns for treatment of caries. If the tooth can be restored with such material, any laboratory-processed crown or jacket is not covered.
7. Tooth and soft tissue preparation, temporary restorations, cement bases, amalgam or acrylic build-ups, pulp capping, impressions, and local anesthesia shall be considered components of and included in the fee for a completed restorative service.
8. Restorations in primary teeth, with no permanent successors, serving as permanent teeth in adults are payable at permanent tooth rates.

9. A provider is responsible for any replacements necessary in primary teeth within the first 12 months and the first 24 months for any restoration in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider.
10. Restorations in primary lower incisors are not payable when the child is over five years of age.

Amalgam Restorations (Procedures 600-614)

1. Procedure 603 represents the maximum allowable fee for all amalgam restorations in a single primary tooth.
2. Procedure 614 represents the maximum allowable fee for all amalgam restorations in a single permanent tooth.

Procedure 600
One Surface, Primary Tooth

Procedure 601
Two Surfaces, Primary Tooth

Procedure 602
Three Surfaces, Primary Tooth

Procedure 603
Four or More Surfaces, Primary Tooth (Maximum)

Procedure 611
One Surface, Permanent Tooth

Procedure 612
Two Surfaces, Permanent Tooth

Procedure 613
Three Surfaces, Permanent Tooth

Procedure 614
Four or More Surfaces, Permanent Tooth (Maximum)

Silicate, Composite, Plastic Restorations (Procedures 640-646)

1. Procedures 640 and 641 include any silicate cement-type filling. Procedure 641 represents the maximum allowable fee for a single anterior tooth.
2. Procedures 645 and 646 shall include any of the plastic, resin, or composite-type materials. Procedure 646 represents the maximum allowable fee for a single anterior tooth, including restoring the incisal angle.
3. Procedures 641 and 646 shall be justified by radiographs and/or narrative documentation.
4. Proximal restorations in anterior teeth are considered single surface restorations.
5. Procedures 640 and 645 are limited to restorations on anterior teeth only and to Class V restorations on first and second bicuspids.
6. Restoration of noncarious lesions is not a benefit, except when necessary in conjunction with traumatic fractures that require treatment.

Procedure 640
Silicate Cement Restoration

Procedure 641
Silicate Restorations, Two or More in a Single Tooth (Maximum)

Procedure 645
Composite or Plastic Restoration

Procedure 646
Composite or Plastic Restorations, Two or More in a Single Tooth (Maximum)

Procedure 648
Pin Retention (Per Pin), Maximum Three Pins Per Tooth

1. A benefit:
    a. When necessary in a permanent tooth to provide mechanical retention because of extensive coronal destruction, and
    b. In three or four surface silver amalgam restorations in permanent posterior teeth, or
    c. In permanent anterior teeth where extensive coronal destruction precludes sufficient mechanical retention of silicate, plastic, or composite restorations.
2. Not a benefit for a permanent tooth when a stainless steel or laboratory-processed crown is used to restore the tooth.

General Policies – Crowns (Procedures 650-672)

1. Laboratory-processed crowns are benefits for permanent teeth if medically necessary pursuant to criteria (a) and (b) below. Periapical radiographs and prior authorization are required.
    a. The overall condition of the mouth, patient attitude, oral health status, arch integrity, and prognosis of remaining teeth shall be considered. The tooth and the remaining teeth must be no more involved than Periodontal Case Types II and III, as defined in General Policies Periodontics (Procedures 450-499), subsection 6.b. Approval will be predicated upon a supportable five-year prognosis.
    b. Longevity is essential and a lesser service will not suffice because extensive coronal destruction as defined below is supported by a narrative documentation, or is radiographically demonstrated and treatment is beyond intercoronal restoration.
        (1) Molars must show traumatic or pathological destruction to the crown of the tooth, which involves four (4) or more tooth surfaces including two (2) or more cusps.
        (2) Anterior teeth must show traumatic or pathological destruction to the crown of the tooth and which involves four (4) or more tooth surfaces including loss of one incisal angle.
        (3) Bicuspids (premolars) must show traumatic or pathological destruction to the crown of the tooth and involves three (3) or more tooth surfaces including one (1) cusp.
2. Laboratory-processed crowns are generally allowable only once in a five-year period.
3. Porcelain crowns, porcelain fused to metal, or plastic processed to metal crowns are not benefits for teeth distal to the second bicuspid. Full cast crowns (660) and three-quarters cast crowns (663) may be authorized for molars.
4. Cast or preformed posts are benefits when necessary for retention of covered crowns in endodontically treated devitalized teeth only.
5. Stainless steel crowns (Procedures 670 and 671) are covered without prior authorization. A provider is responsible for any replacements necessary in primary teeth within the first 12 months and the first 24 months for any stainless steel crown in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider.
6. Laboratory-processed crowns on endodontically treated teeth are covered only after satisfactory completion of the root canal therapy and require prior authorization. Post endodontic treatment x-rays must be submitted for prior authorization of the crowns.
7. The fee for laboratory-processed crowns includes tooth and soft tissue preparation, amalgam or acrylic build-ups, temporary restoration, cement base, insulating bases, impressions, and local anesthesia.

8. Payment for a laboratory-processed crown will be made only upon final cementation of the crown.

Procedure 650
Crown, Plastic (Laboratory Processed)

Procedure 651
Crown, Plastic With Metal

Procedure 652
Crown, Porcelain

Procedure 653
Crown, Porcelain Fused to Metal

Procedure 660
Crown, Cast, Full

Procedure 663
Crown, Cast, Three-Quarters

Procedure 670
Crown, Stainless Steel, Primary

Procedure 671
Crown, Stainless Steel, Permanent

Procedure 672
Gold Dowel Post

PROSTHODONTICS (680-799)

Those dental items considered to be custom-made dental prostheses include fixed bridges and new removable full and partial dentures. Not included are such items as single laboratory-processed crowns (650-663); repair of existing crowns or fixed bridges; or repair, reline, or reconstruction of removable full and partial dentures.

General Policies – Fixed Bridge Pontics (Procedures 680-682, 692, 693)

1. Fixed artificial prostheses are benefits with prior authorization when necessary in order to obtain employment or where medical conditions preclude the use of removable dental prostheses.
   a. A beneficiary with missing natural teeth may qualify for a fixed artificial prosthesis if it is determined that lack of such a prosthesis would interfere with the beneficiary's suitability for employment. A statement from the beneficiary's employer citing the need for fixed replacement of the missing teeth from an employment perspective shall be included with the Treatment Authorization Request.
   b. Medical conditions such as, but not limited to the following which preclude the use of removable dental prostheses:
      (1) The epileptic patient where a removable prosthesis could be injurious to his/her health during an uncontrolled seizure.
      (2) The paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth.
      (3) The spastic person whose manual dexterity precludes proper care and maintenance of a removable appliance.
2. Authorization requests for fixed prostheses will not be approved if the proposed treatment is not medically necessary or when a removable prosthesis is more appropriate for the beneficiary.

Procedure 680
Fixed Bridge Pontic, Cast Metal

Procedure 681
Fixed Bridge Pontic, Slotted Facing

Procedure 682
Fixed Bridge Pontic, Slotted Pontic

Procedure 692
Fixed Bridge Pontic, Porcelain Fused to Metal

Procedure 693
Fixed Bridge Pontic, Plastic Processed to Metal

RECEMENTATION

Procedure 685
Recement Inlay, Facing, Pontic

Procedure 686
Recement Crown

Procedure 687
Recement Bridge

REPAIRS, CROWN, AND BRIDGE

Procedure 690
Repair Fixed Bridge

Procedure 694
Replace Broken Tru-Pontic

Procedure 695
Replace Broken Facing, Post Intact

Procedure 696
Replace Broken Facing, Post Backing Broken

General Policies –
Removable Prosthodontics
(Procedures 700-724)

1. Removable prostheses are benefits, with prior authorization required, using standard procedures which exclude precision attachments, implants, or other specialized techniques.
2. A removable partial denture is a benefit only when necessary for the balance of a complete denture. Balance is generally considered to be the presence of sufficient occluding posterior teeth affording satisfactory biomechanical support of a prosthetic appliance in all excursions of the mandible. Without such occlusion, a removable partial denture may be authorized to provide that support.
3. A removable prosthesis is a benefit only once in a five-year period, except when documentation indicates the necessity to:
   a. Prevent a significant disability, or
   b. Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.
4. The five-year limitation on prosthetic appliances applies only to appliances provided by this program and means that one appliance of each type per arch may be authorized when reasonable and necessary in a five-year period, i.e., one stayplate, one partial denture, one reconstruction, and/or one full denture per arch in the five-year period. A new five-year period commences on insertion of a replacement prosthesis.
5. Replacement prosthetic appliances may be authorized more often than once in a five-year period when:
   a. Catastrophic loss of prosthetic appliance occurs. Requests may be approved for the replacement of a prosthesis that was lost due to some unfortunate incident and the loss of the prosthetic appliance could not reasonably have been prevented, e.g., fire, auto accident, reported theft, etc. and when the loss has been properly documented. The request for prior authorization should include a statement by the beneficiary or the beneficiary's representative explaining the nature of the loss or destruction.
   b. Surgical or traumatic loss of oral-facial anatomic structures occurs.

When a replacement prosthesis is required to replace or restore substantial loss of oral-facial structures by extensive weight loss, surgical intervention, or trauma and adequate documentation supports the request, authorization for the prosthesis may be granted.

c. There has been a complete deterioration of the denture base or teeth.

d. There has been a complete loss of retentive ability, vertical dimension, or balanced occlusion of existing dentures which cannot be restored by reline or reconstruction.

6. Authorization will not be given for a new prosthesis when it is clearly evident that the existing prosthesis can be made serviceable by repair, replacement of broken or missing teeth, reline, or reconstruction (jump). Replacement of a prosthesis for cosmetic reasons will not be authorized.

7. Extraction of all remaining teeth, in preparation for complete immediate dentures, and the immediate full dentures following full mouth extractions (both anterior and posterior) is a benefit and requires prior authorization. There is no insertion fee payable to an oral surgeon who seats an immediate denture.

8. X-rays for edentulous arches are not required for full dentures.

9. Requests for partial dentures and stayplates must include diagnostic x-rays or other justifiable documentation covering the remaining teeth.

10. Construction of new dentures shall not be authorized if conditions including but not limited to the following exist:

    a. It would be impossible or highly improbable for a beneficiary to adjust to a new prosthetic appliance. This is particularly applicable in those cases where the patient has been without dentures for an extended period of time or where the beneficiary may exhibit a poor adaptability due to psychological and/or motor deficiencies.

    b. The dental history shows that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable (psychological).

    c. Repair, relining, or reconstruction of the recipient's present denture will make it serviceable.

    d. The denture, in the patient's opinion only, is loose or ill-fitting but is recently enough constructed to indicate deficiencies limited to those inherent in all dentures.

11. Examination of a denture patient on a maintenance basis is not a benefit.

12. Immediate dentures may be authorized when conditions including but not limited to the following exist:

    a. Extensive or rampant caries are exhibited in the x-rays.

    b. Severe periodontal involvement is indicated by x-rays.

        (1) When the clinical exam shows excessive mobility and severe gingivitis, the request for dentures could be authorized.

        (2) When tooth mobility is not grossly evident and when the gingival tissues are not severely involved, consideration should be given to a more conservative treatment and the denture request denied.

    c. Numerous teeth are missing and masticating ability has been diminished:

        (1) Where there is no capability of any posterior occlusion with existing dentition, the denture request may be authorized.

        (2) When a functional, although minimal, occlusion exists, the urgent need for prosthesis should be carefully evaluated.

        (3) Where the request for the denture(s) is primarily cosmetic, the authorization shall be denied.

13. No allowance is made for temporary dentures to be used while a permanent denture is being constructed.

14. The global fee allowed for any removable prosthetic appliance includes all adjustments necessary for 12 months after insertion of the appliance.
15. All restorative and oral hygiene procedures must be completed before impressions are taken for partial dentures.

Procedure 700
Complete Maxillary Denture

Procedure 701
Complete Mandibular Denture

Procedure 702
Partial Upper or Lower Denture With Two Assembled Wrought Wire or Cast Chrome Cobalt Clasps With Occlusal Rests and Necessary Teeth, Acrylic Base

1. A clasp consists of a metal occlusal post with rest and two clasp arms. Procedure 702 may have either a full or horseshoe palate or metal palatal bar, metal lingual bar, or acrylic lingual with metal reinforcements with acrylic saddles.

Procedure 703
Partial Upper or Lower Denture With Cast Chrome Skeleton, Two Cast Clasps, and Necessary Teeth

Procedure 704
Clasp, Third and Each Additional Clasp for Procedure 703

This clasp must consist of cast chrome occlusal post with rest and two clasp arms.

Procedure 705
Stressbreaker, Extra

1. Simple stressbreakers may be a benefit on any covered mandibular distal extension partial denture.
2. A stressbreaker may be allowable where the extension base must move in order to relieve strain on the abutments.

Procedure 706
Partial Upper or Lower Stayplate, Acrylic Base Fee, Teeth and Clasps Extra

1. Although a stayplate may be authorized to replace an anterior permanent tooth (teeth), posterior teeth, also, may be included where reasonable and necessary; however, a stayplate shall not be authorized to replace posterior teeth only.
2. Relines for stayplates are limited to Procedure 721 Office, cold cure. All other additions, repairs, and reconstructions are allowable at regular fees.

Procedure 708
Partial Upper or Lower Denture, All Acrylic With Two Assembled Wrought Wire Clasps having Two Clasp Arms, But No Rests, and Necessary Teeth

Procedure 709
Clasp, Third and Each Additional for Procedure 708

This clasp must consist of wrought chrome wire having two clasp arms but no rest.

Procedure 712
Clasp, Third and Each Additional for Procedure 702

This clasp may be either cast chrome or wrought chrome wire with occlusal post and rest and two clasp arms.

Procedure 716
Clasp or Teeth, Each for Procedure 706

Allowable for each clasp and/or tooth included in the stayplate.

Procedure 720
Denture Adjustment, Per Visit

1. May be an emergency service, except that it is not payable to the same provider for a period of 12 months following insertion.
2. Payable per visit.
3. Service rendered must be documented.

Procedure 721
Reline-Office, Cold Cure

Office, cold cure relines (Procedure 721) do not require prior authorization and are a benefit once per appliance every 12 months.

Procedure 722
Reline-Laboratory Processed

1. Laboratory-processed relines (Procedure 722) require prior authorization and are a benefit once per appliance every 12 months.
2. A laboratory-processed reline (Procedure 722) generally includes simple repairs to the denture base. Replacement of broken or missing teeth may be allowable as Procedure 753.
3. Soft tissue relines when laboratory processed are payable at the fee allowed for procedure 722 and require prior authorization.

Procedure 723
Tissue Conditioning, Per Denture

1. Tissue conditioning is a benefit subject to prior authorization, to a maximum of two per appliance prior to denture construction, reconstruction, or laboratory reline. Conditioners must be authorized as part of a total treatment plan.

Procedure 724
Denture Duplication ("Jump", "Reconstruction"), Denture Base Including Necessary Tooth Replacement, Per Denture

1. Requires prior authorization and is a benefit:
   a. Once per appliance in a five-year period, and
   b. Only when the existing denture is at least two years old.
2. Generally includes repair, reline, and additions to the denture base to make the appliance serviceable and replacement of broken or missing teeth or the resetting of teeth.

REPAIRS, DENTURES
General Policies - Denture Repairs
(Procedures 750-765)

1. Repairs require full documentation and justification when billing.
2. The first 2 repairs of a single dental prosthetic appliance in a 12-month period are benefits without prior authorization. Subsequent repairs on the same appliance are covered only with prior authorization.
3. Payment for any repair includes all necessary adjustments and remakes for a 12-month period.

Procedure 750
Repair Broken Denture Base Only (Complete or Partial)

Procedure 751
Repair Broken Denture Base and Replace One Broken Denture Tooth (Maximum Two)

Procedure 752
Each Additional Denture Tooth Replaced on 751 Repair (Maximum Two)

Procedure 753
Replace One Broken Denture Tooth Only (Complete or Partial)

Procedure 754
Each Additional Denture Tooth Replaced on 753 Repair (Maximum Two)

Procedure 755
Adding First Tooth to Partial Denture to Replace Newly Extracted Natural Tooth

Procedure 756
Each Additional Natural Tooth Replaced on 755 Repair (Maximum Two)

Procedure 757
Add a New or Replace Broken Chrome Cobalt Assembled Wrought Clasp With Two Clasp Arms and Rest to an Existing 702 Partial Denture

Procedure 758
Each Additional New or Replacement Clasp for Repair 757 (Maximum Two)

Procedure 759
Add a New or Replace Broken Chrome Cobalt Assembled Wrought Clasp With Two Clasp Arms and No Rest to an Existing 708 Partial Denture

Procedure 760
Each Additional New or Replacement Clasp for Repair 759 (Maximum Two)

Procedure 761
Reattaching Clasp on Partial Denture, Clasp Intact, Each (Maximum Two)

Procedure 762
Add a New Clasp or Replace a Broken Cast Chrome Cobalt Clasp With Two Clasp Arms and Rest to an Existing 703 Partial Denture

Procedure 763
Each Additional New or Replacement Clasp for Repair 762 (Maximum Two)

SPACE MAINTAINERS (800-899)
General Policies – Space Maintainers (Procedures 800-899)

1. Space maintainers are a benefit without prior authorization when there is adequate space to allow eruption of a succedaneous permanent tooth, provided:
   a. The permanent tooth has not been extracted, or
   b. Is not congenitally missing, or
   c. Its normal eruption space is adequate.
2. Bitewing x-rays may be adequate for determination of space; if they are not sufficient to document presence and size of the permanent tooth, periapical x-rays must be presented.
3. When lingual bar or palatal arch fixed space maintainers are billed under Procedure 812, one missing primary tooth must be identified on the claim.
4. Orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires are not a benefit.
5. Space maintainers are not a benefit for the upper or lower anterior region.
6. Replacement space maintainers are a one-time only benefit unless documentation identifies an unusual situation requiring an additional replacement.
7. Tongue-thrusting and thumbsucking appliances for beneficiaries with permanent incisors are not benefits.
8. Appliances to hold space for missing permanent teeth are not benefits.
9. Diagnostic study model (Procedure 803) is not a benefit as an independent procedure.

Procedure 800
Fixed, Unilateral Band Type Space Maintainer; (Including Band)

Procedure 801
Removable, Plastic - With Two Stainless Steel Round Wire Clasps or Rests

Procedure 802
Each Additional Clasp or Rest (for 801 Only)

Procedure 811
Fixed, Unilateral, Stainless Steel Crown Type Space Maintainer; (Including Crown Procedures 670 or 671); Space Maintainer

Procedure 812
Fixed, Bilateral, Lingual, or Palatal Bar Type Space Maintainer

Procedure 832
Fixed or Removable Appliance to Control Harmful Habit

FRACTURES AND DISLOCATIONS (900-949)

General Policies - Fractures and Dislocations (Procedures 900-949)

1. These procedures are generally considered emergency procedures and do not require prior authorization.
2. Treatment for these cases includes necessary preoperative and postoperative care for 90 days.
3. A copy of the operating room report or narrative description of services shall accompany the treatment form when submitted for billing.
4. When multiple or bilateral procedures add significant time or complexity to patient care and are provided at the same operative session, the claim must clearly identify and define each procedure which will be valued as follows:

   100% **(full value)** for the first or major procedure
   50% for the second procedure
   25% for the third procedure
   10% for the fourth procedure
   5% for the fifth procedure
   Over five procedures – by report
5. Assistant surgeons (i.e., dentists or physicians) are paid 20 percent of the surgical fee allowed to the surgeon. Bedside visits (Procedure 030) and hospital care (Procedure 035) are not payable to assistant surgeons.

Procedure 900
Maxilla - Open Reduction, Simple

Procedure 901
Maxilla - Closed Reduction, Simple

Procedure 902
Mandible - Open Reduction, Simple

Procedure 903
Mandible - Closed Reduction, Simple

Procedure 904
Maxilla - Closed Reduction, Compound

Procedure 905
Maxilla - Open Reduction, Compound

Procedure 906
Mandible - Closed Reduction, Compound

Procedure 907
Mandible - Open Reduction, Compound

Procedure 913
Reduction of Dislocation of Temporomandibular Joint

Procedure 915
Treatment of Malar Fracture, Simple, Closed Reduction

Procedure 916
Treatment of Malar Fracture, Simple or Compound Depressed, Open Reduction

UNLISTED PROCEDURES (999)

1. Nonemergency unlisted procedures require prior authorization.
2. This procedure number may be used only in those cases where an adequate description of the proposed treatment is not included in the schedule of services.
3. Complete description of the proposed treatment and the need for service must be documented.
4. The fee requested must be listed and is subject to review.

CLEFT PALATE AND ORTHODONTIC SERVICES (550-598)

MAXILLOFACIAL SERVICES (950-998)

General Policies

1. Maxillofacial dental services are covered, subject to prior authorization, when necessity is justified and documented by a dentist qualified under Section 51223 of Title 22, California Code of Regulations (CCR).
2. For the purpose of this section, maxillofacial dental services means anatomic and functional reconstruction of those regions of the mandible and maxilla and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations, and the diagnosis and treatment of temporomandibular joint dysfunction. These procedures may be subject to review by the Department.
3. Orthodontic services are covered in the treatment of cleft palate deformities when under the case management and authorization of California Children Services (CCS) program or when documented and medically necessary under the orthodontic dental services program.
4. Maxillofacial surgical and prosthetic services and temporomandibular joint (TMJ) dysfunction services requests shall be audited individually to determine necessity and reasonableness relative to the intent of the regulations. No requested service will be automatically denied because it does not specifically appear on the list of program benefits and services.
5. All maxillofacial surgical and prosthetic services, TMJ dysfunction services, and orthodontic services require prior authorization except for diagnostic services and those services rendered on an emergency basis. Authorizations by CCS and GHPP (Genetically Handicapped Persons Program) are valid but must meet eligibility, program, and billing requirements.
6. The requirement for prior authorization may be waived where existing medical conditions or a time factor relating to treatment of the patient makes it inappropriate or impossible to obtain adequate preoperative diagnostic information or to delay treatment (i.e., surgical obturator). Approval for payment of services provided in such circumstances rests with the Department, based on submitted documentation justifying failure to obtain prior authorization. Final authority for establishment of the scope and level of benefits and allowable fee for such benefits resides with the Department.
7. Providers should be aware of the separate, specific procedure numbers identifying the maxillofacial and orthodontic services. Frequently, out-of-date or inappropriate procedure numbers or codes have been used by providers in an effort to describe services which are not specifically listed under the schedule of benefits of the maxillofacial/orthodontic dental program. Inappropriate procedure numbers must be modified to reflect maxillofacial dental services when possible. Some procedure numbers (i.e., Nos. 112, 125, 200, etc.) resist modification, however, and must stand as listed.

Explanation of Procedures

1. Procedure 950
Clinical Examination and Consultation, Including Study Models

a. A benefit once per patient per dentist per treatment series.

b. Diagnostic services may include, but are not limited to: medical and dental history, documentation of clinical examination, identification of TMJ syndrome, diagnosis, and treatment plan.

c. Allowable in relation to maxillofacial surgical services and TMJ dysfunction services where a complete diagnostic package is presented.

d. In relation to surgical services, sufficient diagnostic materials must be presented to justify the need for anatomic or functional reconstruction. Aesthetic or cosmetic enhancement may be a byproduct of such reconstruction

but cannot be the primary motivation for the reconstruction.

e. In relation to TMJ dysfunction, sufficient diagnostic material must be presented in order to identify the TMJ syndrome or the TMJ Triad:

(1) Intrinsic or extrinsic predisposition;

(2) Tissue alteration;

(3) Psychologic component.

2. Procedure 952
Prosthetic Evaluation and Treatment Plan, Including Study Models

a. A benefit only in relation to requests for fabrication of cleft palate or maxillofacial prosthetic devices.

b. May include, but not limited to, medical and dental history, documentation of clinical examination, diagnosis, treatment plan (including design or description of prosthesis).

3. Procedure 955
TMJ Series Radiographs

a. Payable primarily for tomographic projections of TMJ. Must include six tomographic views (right and left sides at rest, open and closed) plus one panographic projection.

b. Any other films (panographic, lateral, cephalometric, etc.) will be identified by specific procedure numbers and paid as such.

4. Procedure 956-957
Cephalometric Head Film (One View, Each Additional View)

a. A cephalogram is a roentgenogram taken with the patient's head in a specific fixed position from which standardized measurements can be made; not to be confused with a lateral head or jaw roentgenogram.

b. Payable as needed for diagnostic purposes.

c. Tracings and measurements, when presented, are considered part of and included in the global fee for cephalogram.

5. Procedure 960-968
Cleft Palate Prostheses

a. Any necessary restorative procedures, including full coverage of abutments, may be included in treatment plans where longevity is essential.

b. Where the ridge defect is small, a fixed anterior prosthesis may be used to replace missing anterior teeth and stabilize a mobile premaxilla in conjunction with a removable obturator and/or speech appliance.

c. A removable prosthesis may be preferred when there is a large anterior ridge defect and/or the middle third of the face is depressed.

d. Treatment plans related to correction of cleft palate deformities authorized by CCS are a benefit when eligibility, program, and billing requirements are met.

e. Fees for by-report items will be determined on the basis of comparable or the closest comparable items listed in the schedule of maximum allowances (SMA) or RVS when related to the difficulty, time, and skill necessary in performing the service.

f. The global fee of each cleft palate prosthesis includes all normal follow-up care, revisions, and adjustments for 90 days after delivery.

g. A detailed description or photograph of the prosthesis may be required for payment.

6. Procedure 970-976
Maxillofacial Prosthetic Reconstruction

a. Most prosthetic devices constructed by a dentist for the rehabilitation of patients with congenital, developmental, or acquired defects of the mandible or

maxilla and associated structures are benefits.

b. A detailed description of the defect and device must be submitted in order to determine the appropriate allowable device to be authorized or paid. A photograph of the defect and device may be required.

c. Fees for by-report items will be determined on the basis of the closest comparable items listed in the SMA or RVS and related to difficulty, time, and skill necessary in performing the service.

7. Procedure 977-982
Miscellaneous Maxillofacial Services

a. Most extraoral maxillofacial prostheses constructed by a dentist may be included in this section.

b. Where prosthetic devices are listed or described in other areas of the Medi-Cal program, that allowable fee will apply (i.e., No. 6483 Artificial eye stock).

c. Splints and stents to be used in conjunction with allowable surgical procedures are included in the global fee for the surgical procedures, except where such splints and stents are extremely complicated and are more elaborate than normally expected. A detailed description or photo of the splint or stent may be required for payment to be made.

d. Opposing appliances are allowable only when necessary for the balance or retention of the primary device.

e. The allowable fee for repairs and relines of maxillofacial devices will be determined by comparison on a difficulty, time, and skill basis to procedures listed in the SMA or RVS.

f. Fabrication of splints or stents by a dentist on the prescription of a physician is a benefit when the service is not included in the global fee for the surgery.

8. Procedure 985
Surgical Services

a. Maxillofacial surgical services are a benefit for the anatomic and functional reconstruction of those structures missing, defective, or deformed because of surgical intervention, trauma, pathology, or developmental or congenital malformations. Cosmetic or esthetic enhancement may result from such surgical services but cannot be the primary motivation for surgical services.

b. Fees for these maxillofacial surgical services shall be calculated on the basis of current RVS unit value listed in the 1974 revision of the 1969 RVS or the 1969-1974 RVS and according to the standards established therein.

c. Authorization of surgical procedures is dependent upon verification of need by examination of submitted diagnostic material or clinical examination. Confirmation of extent of procedures provided will be made from the operative report submitted at the time of billing.

9. Procedure 990-998
TMJ Dysfunction Management

a. The TMJ services are limited to differential diagnosis and symptomatic care, excluding those TMJ treatment modalities involving prosthodontia, orthodontia, and full or partial occlusal rehabilitation.

b. Services in the treatment of TMJ dysfunction may be provided subject to prior authorization only for those beneficiaries where the TMJ syndrome has been established by differential diagnostic procedures. Presentation of sufficient diagnostic information to establish the presence of the syndrome is required. The diagnostic evaluation must be sufficiently extensive to identify the TMJ syndrome, eliminating other disease entities which have similar signs and symptoms as those of TMJ dysfunction.

c. In accordance with the American Academy of Craniomandibular Orthopedics, treatment modalities are divided into three groups according to the extent of their complexity. Symptomatic care enables a reversible type therapy, whereas major and minor definitive care in their more complex forms become more invasive and nonreversible. Symptomatic care over a reasonable period of time must demonstrate amelioration of painful symptoms before major definitive care may be authorized.

An attempt at symptoms reversal may have diagnostic value, but there is a fine line between diagnostic and treatment modalities. Acceptable treatment modalities may include, but are not limited to, the following:

(1) Symptomatic Therapy

(a) Diagnostic anesthetic blocks (per injection) as well as physical medicine modalities.

(b) Appliances such as orthopedic stabilizing appliance disocclusion splint, and orthopedic repositioning appliance (hard or soft) may be authorized as Procedure 995.

(2) Minor Definitive Temporomandibular Therapy

(a) Occlusal analysis, including study models, may be authorized and paid under Procedure 990 when documentation or grind models identify procedures which would:

i. Convert lateral forces to vertical forces.

ii. Confine vertical forces within that part of the crown supported by the root.

iii. Reduce size of contacts.

iv. Establish a series of symmetrical contacts.

v. Reduce mobility from wedging and rocking forces.

vi. Increase horizontal overlap (overjet), decrease vertical overlap (overbite).

(b) Occlusal Equilibration, Limited Centric and Excursive Adjustment, Procedure 992, are benefits when documentation or grind models indicate relief of centric, protrusive, working, and balancing prematurities. Usually authorized as minor definitive care except when necessary to eliminate obvious and destructive prematurities during symptomatic care.

(c) Restorative and prosthetic services covered under the program may be authorized as Minor Definitive Therapy.

(3) Major Definitive Temporomandibular Therapy

(a) Occlusal Equilibration, Altering Centric Occlusion, Procedure 994, is a benefit only when documentation verifies the elimination of destructive occlusal forces with the establishment of a centric neutroclusion. Submission of grind models or charts may be required for authorization.

(b) Restorative and prosthetic services available under the program may be authorized as Major Definitive Therapy.

10. Procedure 995
Orthopedic Stabilizing Appliance, Disocclusion Splint

11. Procedure 996
Postoperative Visit, Symptomatic Care and Counseling

a. May be authorized to cover nonspecific care, pre- or postoperative, necessary in relation to temporomandibular therapy when specific services are listed. Routine adjustments of

prostheses, splints, or orthopedic stabilizing devices are not benefits.

b. Payable as an emergency service for the nonspecific symptomatic care of temporomandibular symptoms.

12. Procedure 998
Unlisted Therapeutic Service

a. To be used only in cases where an adequate description of the proposed treatment is not included in the Maxillofacial-Orthodontic schedule of services.

b. May be used to identify any service as a maxillofacial-orthodontic service when listed description of procedure number is not appropriate to the Maxillofacial-Orthodontic program.

c. A complete description of service or treatment and a justification of need must be present to be payable.

ORTHODONTIC SERVICES

1. Malocclusion Cases

Procedure 551
Initial Orthodontic Examination/Handicapping Labio-Lingual Deviation Index.

Procedure 552
Banding and materials.

Procedure 554
Per treatment visit - 24 visits maximum. One visit maximum per calendar month.

Procedure 557
Diagnostic Work-up and Photographs (additional dental services are listed separated in 22 CCR, Section 51506(b), Procedure Code 112 - Intraoral, complete series; and Section 51506.1(b), Procedure Codes 956 and 957 - Cephalometric Head Films, including tracing).

Procedure 558
Study Models

2. Cleft Palate Services

a. Primary Dentition

Procedure 560
Diagnostic work-up - photos, and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule).

Procedure 562
Banding and materials

Procedure 564
Per treatment visit - 10 visits maximum. One visit maximum per calendar month.

b. Mixed Dentition
Procedure 570
Banding and materials

Procedure 572
Per treatment visit - 14 visits maximum. One visit maximum per calendar month.

c. Permanent Dentition
Procedure 580
Banding and materials

Procedure 582
Per treatment visit - 30 visits maximum. One visit maximum per calendar month.

3. Facial Growth Management

Procedure 590
Diagnostic work-up - photos, and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule).

Procedure 592
Quarterly observation 6 quarters maximum

Procedure 594
Progress records prior to treatment

Procedure 596
Banding and materials

Procedure 598

Per treatment visit - 24 visits maximum. One visit maximum per calendar month.

4. Malocclusion, Cleft Palate, and Facial Growth Management Cases - Retention

Procedure 556
Quarterly observation, 6 quarters maximum

Procedure 599
Retainer, removable, for each upper and lower

MAXILLOFACIAL DENTAL SERVICES

1. Diagnostic Services

Procedure 950
Clinical examination and consultation including study models

Procedure 952
Prosthetic evaluation and treatment plan including study models

Procedure 955
TMJ series radiographs

Procedure 956
Cephalometric head film - single, first film, including tracing

Procedure 957
Cephalometric head film - each additional film including tracing

2. Maxillofacial Prosthetic Services

Procedure 960
Speech appliance, transitional, with or without pharyngeal extension

Procedure 962
Speech appliance, permanent, edentulous, with or without pharyngeal extension

Procedure 964
Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension

Procedure 966
Palatal lift, interim

Procedure 968
Palatal lift, permanent cast framework

Procedure 970
Obturator, immediate surgical, routine

Procedure 971
Obturator, immediate surgical, complex

Procedure 972
Obturator, permanent, complex

Procedure 973
Resection prosthesis, permanent, edentulous, complex

Procedure 974
Resection prosthesis, permanent, edentulous, routine

Procedure 975
Resection prosthesis, permanent, partially edentulous, complex

Procedure 976
Repositioner, mandibular, two piece

Procedure 977
Removable facial prosthesis

Procedure 978
Splints and stents

Procedure 979
Radiation therapy fluoride carrier

Procedure 980
Repairs, maxillofacial prosthesis

Procedure 981
Rebase, laboratory processed maxillofacial prosthesis

Procedure 982
Balancing (opposing) maxillofacial appliance

Procedure 985
Maxillofacial surgical procedures

3. Temporomandibular Joint Dysfunction Management

Procedure 990
Occlusal analysis including report and/or models

Procedure 992
Occlusal adjustments, limited centric and excursive adjustments including records and/or models

Procedure 994
Occlusal balancing, altering centric relation including records and/or models

Procedure 995
Orthopedic stabilizing appliance, disocclusion splint

Procedure 996
Postoperative visits, symptomatic care, and counseling

Procedure 998
Unlisted therapeutic service

ORTHODONTIC SERVICES FOR HANDICAPPING MALOCCLUSION

General Policies and Requirements

1. The provision of medically necessary orthodontic services for handicapping malocclusion is limited to Medi-Cal eligible individuals under 21 years of age by dentists qualified as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
2. The following policies and requirements apply to orthodontic services for handicapping malocclusion:
   a. The initial orthodontic examination, including the Handicapping Labio-Lingual Deviation (HLD) Index (Procedure code 551), is used to screen patients, and for submission of a TAR to prior authorize study models. Subsequent Study Models (Procedure Code 558) are required to establish the medical necessity for orthodontic services for handicapping malocclusion. The HLD Index is the preliminary measurement tool used to determine the degree of the handicapping malocclusion. Completion of the initial orthodontic examination which includes the HLD Index does not require prior authorization. All other orthodontic services, require prior authorization.
   b. A minimum score of 26 points on the HLD Index, or the indication that any of the five conditions listed below are present, or a determination that orthodontic services are otherwise medically necessary as set forth in 22 CCR section 51340.1(a)(2)(B), is required for prior authorization of study models. The study model findings must confirm that at least the minimum score is attained on the HLD Index, that one of the five conditions listed below is present, or that orthodontic services are otherwise medically necessary as set forth in 22 CCR section 51340.1(a)(2)(B) in order to obtain prior authorization of medically necessary orthodontic services. This paragraph is not intended to preclude authorization of x-rays and/or photographs in addition to study models in cases where medically indicated.
      (1) Cleft palate deformities; or
      (2) Deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate; or
      (3) Crossbite of individual anterior teeth when destruction of soft tissue is present; or
      (4) Overjet greater than nine (9) mm with incompetent lips, or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties; or
      (5) Severe traumatic deviations: For example, with loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology.
   c. Only cases with permanent dentition will be considered.
   d. Only cases with satisfactory completion of all necessary restorative and periodontal conditions will be considered.
3. The general policies and requirements for orthodontic services for handicapping malocclusion apply to cases of cleft palate deformities unless the patient's care is under the case management and authorization of the California Children Services program or when documented and medically necessary under the orthodontic dental services program.
4. Completion of the HLD Index is limited to the provider or provider group that per-

forms the examination with the intention of providing any subsequent medically necessary orthodontic services.

5. All appliances required for medically necessary orthodontic services for handicapping malocclusion are to be furnished by the attending orthodontist and are considered part of the services for which fees are paid. No additional charge to either the Denti-Cal program or the patient is permitted.
6. Patient transfers from one orthodontist to another orthodontist require prior authorization.
7. The maximum allowable visits are set forth in Section 51506.2. However, twelve additional visits for procedure code 554 may be prior authorized when documentation necessitates the need for further treatment. Documentation may include, but is not limited to, study models, radiographs, photographs and/or narrative descriptions.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

1. The EPSDT program is a federally mandated Medicaid benefit for eligible individuals up to 21 years of age.
2. Under the EPSDT program regulations, which are filed in Title 22, California Code of Regulations, Section 51340, if a beneficiary does not qualify for orthodontic benefits by scoring 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index, he or she could still be eligible for orthodontic benefits.
3. All requests for services under the EPSDT program must be prior authorized.
4. The provider should identify the treatment requested as EPSDT by indicating "EPSDT" in the comments area (box 34) on the Treatment Authorization Request (TAR) form.
5. All TARs must have attached medical evidence and documentation that meets all of the following requirements:
    a. principle diagnosis and significant associated diagnosis; and
    b. prognosis; and
    c. date of onset of the illness or condition, and etiology, if known; and
    d. clinical significant or functional impairment caused by the illness or condition; and
    e. specific types of services to be rendered by each discipline associated with the total treatment plan; and
    f. the therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals; and
    g. the extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care; and
    h. any other documentation available which may assist Department of Health Services in making the required determinations. This will include x-rays and/or documentation for adjudication.

When the EPSDT TAR is submitted to Denti-Cal, it will be referred to the Department of Health Services for evaluation and returned to Denti-Cal for final processing once a decision has been made.

HLD Index Form

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX SCORESHEET

(You will need this Scoresheet and a Boley Gauge or a disposable ruler.)

Provider **Patient**

Name: _____ **Name:** _____

Number: _____ **SSAN:** _____

Procedure

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE "0" IF CONDITION IS ABSENT.
- If anterior crowding and an ecoptic eruption are present in the anterior portion of the mouth, score only the most severe condition.
- The use of a recorder (hygienist, assistant) is recommended.

Conditions (#1 - 4 AND 5A ARE AUTOMATIC QUALIFYING CONDITIONS FOR AUTHORIZATION OF STUDY MODELS.) **HLD Score**

1. Cleft palate deformities
(Indicate an "X" if present and score no further) . . . . . _____

2. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE**
(Indicate an "X" if present and score no further) . . . . . _____

3. Crossbite of individual anterior teeth **WHEN DESTRUCTION OF SOFT TISSUE IS PRESENT**
(Indicate an "X" if present and score no further) . . . . . _____

4. Severe traumatic deviations. (Attach description of condition. For example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology.)
(Indicate an "X" if present and score no further) . . . . . _____

5A. Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties.
(Indicate an "X" if present and score no further) . . . . . _____

5B. Overjet in mm . . . . . _____

6. Overbite in mm . . . . . _____

7. Mandibular protrusion in mm . . . . . _____ x 5 = _____

8. Open bite in mm . . . . . _____ x 4 = _____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT SCORE BOTH CONDITIONS.

9. Ectopic eruption (Count each tooth, excluding third molars) . . . . . _____ x 3 = _____

10 Anterior crowding (Score one point for MAXILLA and/or one point for MANDIBLE; two points maximum for anterior crowding) . . . . . _____ x 5 = _____

11. Labio-Lingual spread in mm . . . . . _____

12. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar) . . . . . Score 4 _____

TOTAL SCORE: _____

NOTE: A SCORE OF 26 OR MORE QUALIFIES FOR AUTHORIZATION OF STUDY MODELS

IF A BENEFICIARY DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE FIVE AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EPSDT EXCEPTION, IF MEDICAL NECESSITY IS DOCUMENTED.

☐ **EPSDT EXCEPTION:** (Indicate with an "X" and attach medical evidence and appropriate documentation for each of the following eight areas in addition to completing the "CONDITIONS SECTION.")

a) Principal diagnosis and significant associated diagnosis; and
b) Prognosis; and
c) Date of onset of the illness or condition and etiology if known; and
d) Clinical significance or functional impairment caused by the illness or condition; and
e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
g) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care; and
h) Any other documentation which may assist the Department in making the required determinations.

DC0016 (R 8/98)

Instructions for the HLD Index Form

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX
SCORING INSTRUCTIONS

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering "0." (Refer to the attached scoresheet).

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformities:** Indicate an "X" on the scoresheet. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

2. **Deep Impinging Overbite:** Indicate an "X" on the scoresheet when lower incisors are destroying the soft tissue of the palate. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

3. **Crossbite of Individual Anterior Teeth:** Indicate an "X" on the scoresheet when destruction of soft tissue is present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Severe Traumatic Deviations:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident, the result of osteomyelitis; or other gross pathology. Indicate with an "X" on the scoresheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Overjet in Millimeters:** This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the scoresheet. If the overjet is greater than 9mm with incompetent lips or the reverse overjet is greater than 3.5mm with reported masticatory and speech difficulties, indicate an "X" and score no further. If the reverse overjet is not greater than 3.5mm, score under #7.

6. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the scoresheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

7. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement in millimeters is entered on the scoresheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite."

8. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. The measurement is entered on the scoresheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

9. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the scoresheet and multiply by three (3). If condition No. 10, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. **DO NOT SCORE BOTH CONDITIONS.**

10. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points each for maxillary and mandibular anterior crowding. If condition No. 9, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. **DO NOT SCORE BOTH CONDITIONS.**

11. **Labio-Lingual Spread:** A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labio-lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index.

12. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the scoresheet.

Appendix

1. Preoperative Clinical Examinations

a. Shall be used to verify existing conditions and the necessity for requested services.

b. Clinical examination shall be used only when other means of verification are not available to establish necessity.

c. It is the responsibility of the provider to supply sufficient diagnostic material to establish the necessity for the requested services.

d. The consultant's responsibility is to approve only those procedures identified as necessary from the diagnostic material or other documentation submitted.

e. Clinical examinations shall not be routinely used to gather information which should be supplied by the provider. The provider shall be requested to supply necessary additional information when needed.

f. Clinical examinations shall not be used for those cases where the outcome of screening will not alter the decision.

g. Clinical examinations may be used for review and control of unusual treatment patterns.

Examples

(1) Request for alveolectomy or tori removal subsequent to removal of remaining teeth.

(2) Cases involving suspected overutilization.

(3) Requests for stainless steel crowns where more conservative measures appear more appropriate.

2. Postoperative Clinical Examinations

Sufficient numbers of completed dental procedures of each service type (restorations, denture, etc.) shall be examined to ensure that quality services are being provided.

3. Emergency Dental Services

Within the scope of dental care benefits under the program, emergency dental services may comprise those diverse professional services required in the event of unforeseen medical conditions such as hemorrhage, infection, or trauma. Emergency dental services shall not require prior authorization whether the service is performed as an outpatient service or an inpatient service; however, emergency services shall conform to requirements in Title 22, California Code of Regulations (CCR), Section 51056. Examples of emergency conditions may include, but are not limited to, the following:

a. High risk-to-life or seriously disabling conditions, such as cellulitis, oral hemorrhage, and traumatic conditions.

b. Low risk-to-life or minimally disabling conditions, such as painful low grade oral-dental infections, near pulpal exposures, fractured teeth or dentures, where these conditions are exacerbated by psychiatric or other neurotic states of the patient.

Possible emergency dental treatment may include, but is not limited to: antibiotics administrations; prescriptions of analgesics or antibiotics; temporary or permanent filling; pulpal treatment, including root canal treatment where sedative holding measures are not effective; biopsy; denture repair or adjustment; treatment of evulsed teeth; control of fracture and traumatic or postoperative bleeding; treatment of Vincent's infection or pericoronitis. Construction of dentures and/or denture relining are not emergency services.

4. Reasonable and Necessary Concept

Title 22, California Code of Regulations (CCR), Section 51307, states that outpatient and inpatient dental services which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury, or defect are covered to the extent specified in this section when fully documented to be medically necessary.

The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item, which is a program benefit, is fully documented to be immediately necessary, is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Authorization shall be granted or reimbursement made only for the lowest cost covered service appropriate to the presenting adverse condition.

5. Grievance and Complaint Procedures

Grievance and complaint procedures for both beneficiaries and providers are maintained in order to resolve or adjudicate differences in professional judgments or opinions, misunderstandings in prior authorization or payment policies, and interpretation of the level and scope of benefits of the Denti-Cal program.

a. Beneficiary Grievances or Complaint Procedures

A Medi-Cal beneficiary with a grievance or complaint concerning scope of benefits, quality of care, or other aspect of services provided under the dental program shall direct his grievance or complaint as follows:

(1) Any agency, department, or individual accepting the initial information regarding a grievance or complaint shall advise the beneficiary to direct his grievance or complaint to the dental provider responsible for the dental needs of the beneficiary. The beneficiary shall initiate action by submitting his grievance or complaint to his dentist, identifying the grievance or complaint by specifically describing the disputed service, action, or inaction. The dentist responsible for the dental needs of the beneficiary shall attempt to resolve the grievance or complaint within the parameters of the dental program.

(2) Where the action at the provider level fails to resolve the grievance or complaint, the beneficiary should write or telephone the contractor (Delta Dental Plan), identifying himself, the provider involved, and specifically describe the disputed services, action, or inaction. The contractor shall make every effort to resolve the problem at this level.

The contractor shall acknowledge the written grievance or complaint within seven working days of receipt. The written grievance shall be referred to a dental consultant who shall determine the next course of action, which could be contacting the patient and/or dentist, examining the patient, or referral to the appropriate peer review body. The contractor will review the grievance or complaint and send a written report of its conclusions and reasons therefore to the beneficiary and the provider with a copy to DHS within 60 days of the acknowledgment of the receipt of the grievance or complaint.

(3) Where the contractor refers such a grievance or complaint to the peer review body of the professional organization concerned, the involved provider and beneficiary shall be notified that the referral has been made. The contractor, after taking into consideration the findings and recommendations of the peer review body, shall take such actions as it deems necessary or appropriate. The contractor shall send a written report of its conclusions and reasons therefore

to the beneficiary and the provider with a copy to DHS within 15 days of the receipt of the findings and recommendations of the peer review body.

Where a decision is not forthcoming within 60 days of the acknowledgment of the receipt of the grievance or complaint, the contractor shall send a written report of the status and expected date of final decision and reasons therefore to DHS.

(4) If any party is dissatisfied with the decisions or conclusions and has followed the procedures set down in this grievance procedure, he shall be informed of his right of appeal to DHS.

Receipt of written appeals submitted to the Department shall be acknowledged within seven working days. The Department shall review the written documents submitted, may ask for additional information, may hold an informal meeting with involved parties, or perform other actions as necessary and shall send a written report of its conclusions and reasons therefore to the parties involved within 60 days of the acknowledgment of receipt of the appeal.

(5) At any point in the grievance or complaint procedure, the beneficiary may contact the State Department of Social Services, which shall advise him of all rights to a fair hearing available to him under state and federal law and Section 50951 of Title 22.

b. Provider Grievance or Complaint Procedures

In accordance with Title 22, CCR, Section 51015, the contractor shall establish, implement, and maintain a procedure approved by DHS for recording and handling provider grievances or complaints concerning the processing or payment for claims for services provided under the Medi-Cal dental program. The contractor shall advise providers in writing that complaints or grievances are to be directed as provided in Title 22, CCR, Section 51015.

6. Hospital Care

Inpatient dental services (hospitals, SNFs, and ICFs) are covered only when provided on the signed order of the provider responsible for the care of the beneficiary. A claim for inpatient dental services must show verification that the services are to be rendered on the signed order of the admitting physician or dentist.

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DENTI-CAL ENDS
PROVIDER PAYMENT REDUCTIONS

Effective for dates of service on or after March 4, 2006, Denti-Cal has ended the five percent (5%) payment reduction for program services, in accordance with Senate Bill (SB) 912, (Statutes of 2006, Chapter 8). The five percent (5%) reduction was implemented January 1, 2006, in accordance with *Welfare and Institutions Code*, §14105.19.

The following were exempt from the payment reduction and will see no change in Denti-Cal payments:

- Breast and Cervical Cancer Early Detection Program (BCCEDP)
- Breast Cancer Control Program
- California Children's Services (CCS) Program (both Medi-Cal and non Medi-Cal)
- Child Health and Disability Prevention (CHDP) Program (both Medi-Cal and non Medi-Cal)
- Genetically Handicapped Persons Program (GHPP)

Because the five percent (5%) reduction was previously implemented for payments to managed care plans, ending of the payment reduction described in this notice does not apply to managed care plans.

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DENTI-CAL SCHEDULE OF MAXIMUM ALLOWANCES

1. Fees payable to providers by Denti-Cal for covered services shall be the LESSER of:
   a. provider's billed amount
   b. the maximum allowance set forth in the schedule below
2. Refer to your Denti-Cal Provider Manual for specific procedure instructions and program limitations.

Procedure Number	Procedure Description	Maximum Allowance
Visits - Diagnostic (Procedures 010-099)		
010	Complete examination, initial episode of treatment only	25.00
015	Examination periodic (annual)	15.00
020	Office visit during regular office hours, for treatment and/or observation of teeth or supporting structures	20.00
030	Professional visit after regular office hours or to bedside	35.00
035	Hospital care	50.00
040	Specialist consultation	35.00
045	Pit and fissure dental sealants for permanent first molars, beneficiaries to age twenty-one (21)	22.00
046	Pit and fissure dental sealants for permanent second molars, to age twenty-one (21)	22.00
049	Prophylaxis, beneficiaries through age 12	30.00
050	Prophylaxis, beneficiaries age 13 years of age and over	40.00
061	Prophylaxis, including topical application of fluoride, beneficiaries age 5 and under	35.00
062	Prophylaxis, including topical application of fluoride, beneficiaries age 6 through 17 years of age	40.00
080	Emergency treatment, palliative	45.00
Radiographs and Photographs (Procedures 110-125)		
110	Intraoral periapical, single, first radiograph	10.00
111	Intraoral periapical, each additional radiograph	3.00
112	Intraoral, complete series	45.00
113	Intraoral, occlusal radiograph	10.00
114	Extraoral, single, head or lateral jaw	22.00
115	Extraoral, each additional head or lateral jaw	5.00
116	Bitewings, two radiographs	10.00
117	Bitewings, four radiographs	18.00
118	Bitewing, anterior, one radiograph	5.00
119	Photograph or slide, first	7.00
120	Photograph or slide, each additional (maximum five)	3.00
125	Panographic-film, single radiograph	25.00

Pro-cedure Number	Procedure Description	Maximum Allowance
Biopsy and Pathology Reports (Procedures 150-199)		
150	Biopsy of oral tissue	100.00
160	Gross and microscopic histopathological examination	50.00
Oral Surgery (200-299)		
200	Removal of erupted tooth, uncomplicated, first tooth	45.00
201	Removal of erupted tooth (teeth), uncomplicated, each additional tooth	38.00
202	Removal of erupted tooth, surgical	85.00
203	Removal of root or root tip completely covered by bone	100.00
204	Removal of root or root tip not completely covered by bone	40.00
220	Postoperative visit, complications e.g., osteitis	15.00
230	Removal of impacted tooth, soft tissue	100.00
231	Removal of impacted tooth, partial bony	135.00
232	Removal of impacted tooth, complete bony	165.00
250	Alveoloplasty per quadrant, edentulous	100.00
252	Alveoloplasty per quadrant, in conjunction with extractions	50.00
255	Vestibuloplasty, submucosal resection (not to include grafts)	400.00
256	Alveoloplasty with ridge extension, secondary epithelialization (per arch)	200.00
257	Removal of palatal exostosis (torus)	200.00
258	Removal of mandibular exostosis (torus) per quadrant	100.00
259	Excision of hyperplastic tissue (per arch)	100.00
260	Incision and drainage of abscess, intraoral	50.00
261	Incision and drainage of abscess, extraoral	75.00
262	Excision pericoronal gingiva, operculectomy	50.00
263	Sialolithotomy, intraoral	235.00
264	Sialolithotomy, extraoral	300.00
265	Closure of salivary fistula	120.00
266	Dilation of salivary duct	120.00
267	Reduction of tuberosity, unilateral	75.00
269	Excision of benign tumor, up to 1.25 cm	100.00
270	Excision of benign tumor, larger than 1.25 cm	250.00
271	Excision of malignant tumor	325.00
273	Reimplantation and/or stabilization of accidentally evulsed or displaced permanent tooth and/or alveolus	175.00
275	Transplantation of tooth or tooth bud	1000.00
276	Removal of foreign body from bone (independent procedure)	130.00
277	Radical resection of bone for tumor with bone graft	1200.00
278	Maxillary sinusotomy for removal of tooth fraction or foreign body	380.00
279	Oral antral fistula closure	300.00
280	Excision of cyst up to 1.25 cm	100.00
281	Excision of cyst over 1.25 cm	200.00
282	Sequestrectomy	100.00
285	Condylectomy of mandible, unilateral	1000.00

Procedure Number	Procedure Description	Maximum Allowance
289	Menisectomy of temporomandibular joint, unilateral	1000.00
290	Excision of foreign body, soft tissue	60.00
291	Frenectomy, or frenotomy, separate procedure	100.00
292	Suture of soft tissue wound or injury	50.00
294	Injection of sclerosing agent into temporomandibular joint	75.00
295	Injection of trigeminal nerve branches for destruction	200.00
296	Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissues	100.00
297	Surgical exposure of impacted or unerupted tooth to aid eruption, partial bony	135.00
298	Surgical exposure of impacted or unerupted tooth to aid eruption, complete bony	135.00
299	Unlisted surgical service or procedure	By Report
Drugs and Anesthesia (300-400)		
300	Therapeutic drug injection	15.00
301	Conscious sedation, relative analgesia (nitrous oxide), per visit	25.00
400	General anesthesia	100.00
Periodontics (450-499)		
451	Emergency treatment (periodontal abscess, acute periodontitis, etc.)	55.00
452	Subgingival curettage and root planing, per full mouth treatment	118.00
	(residents of SNF or ICF)	200.00
453	Occlusal adjustment (limited) per quadrant (minor spot grinding)	25.00
472	Gingivectomy or gingivoplasty per quadrant	166.00
473	Osseous and mucogingival surgery per quadrant	350.00
474	Gingivectomy or gingivoplasty, treatment per tooth (fewer than six teeth)	50.00
Endodontics (500-599)		
501	Therapeutic pulpotomy	71.00
502	Vital pulpotomy	71.00
503	Recalcification, includes temporary restoration, per tooth	41.00
511	Anterior root canal therapy; and	215.00
512	Bicuspid root canal therapy; and	260.00
513	Molar root canal therapy	330.00
530	Apicoectomy - surgical procedure in conjunction with root canal filling	300.00
531	Apicoectomy (separate surgical procedure) per tooth	100.00
534	Apexification/Apexogenesis (therapeutic apical closure, per treatment)	100.00

Procedure Number	Procedure Description	Maximum Allowance
Orthodontic Services (551-599)		
Malocclusion Cases		
551	Initial orthodontic examination/handicapping labio-lingual deviation index	35.00
552	Banding and materials	650.00
554	Per treatment visit - 24 visits maximum. One visit maximum per calendar month.	70.00
556	Quarterly observation 6 quarters maximum	50.00
557	Diagnostic work-up and photographs (additional dental services are listed separately in 22 CCR, Section 51506(b), Procedure Code 112 - intraoral, complete series; and Section 51506.1(b), Procedure Codes 956 and 957 cephalometric head films, including tracing).	100.00
558	Study models	75.00
Cleft Palate Services		
560	Diagnostic work-up - photos, and study models (complete mouth series radiographs, Procedure Code 112, and cephalometric head films, Procedure Codes 956 and 957 including tracing, are separately payable at State fee schedule).	200.00
Primary Dentition		
562	Banding and materials	300.00
564	Per treatment visit - 10 visits maximum. One visit maximum per calendar month.	50.00
Mixed Dentition		
570	Banding and materials	500.00
572	Per treatment visit - 14 visits maximum. One visit maximum per calendar month	50.00
Permanent Dentition		
580	Banding and materials	800.00
582	Per treatment visit - 30 visits maximum. One visit maximum per calendar month.	100.00
Facial Growth Management		
590	Diagnostic work-up - photos, and study models (complete mouth series radiographs, Procedure Code 112, and cephalometric head films, Procedure Codes 956 and 957 including tracing, are separately payable at State fee schedule).	100.00
592	Quarterly observation 6 quarters maximum	50.00
594	Progress records prior to treatment	100.00
596	Banding and materials	800.00
598	Per treatment visit 24 visits maximum. One visit maximum per calendar month.	100.00
Malocclusion, Cleft Palate and Facial Growth Management Cases - Retention		
556	Quarterly observation, 6 quarters maximum	50.00
599	Retainer, removable, for each upper and lower	200.00

Pro-cedure Number	Procedure Description	Maximum Allowance
Restorative Dentistry (600-679)		
Amalgam Restorations		
600	One surface, primary tooth	35.00
601	Two surfaces, primary tooth	43.00
602	Three surfaces, primary tooth	50.00
603	Four or more surfaces, primary tooth (maximum)	57.00
611	One surface, permanent tooth	39.00
612	Two surfaces, permanent tooth	48.00
613	Three surfaces, permanent tooth	57.00
614	Four or more surfaces, permanent tooth (maximum)	60.00
Silicate, Composite, Plastic Restorations		
640	Silicate cement restoration	0.00
641	Silicate restorations, two or more in a single tooth (maximum)	0.00
645	Composite or plastic restoration	55.00
646	Composite or plastic restorations, two or more in a single tooth (maximum)	85.00
648	Pin retention (per pin), maximum three pins per tooth	80.00
Crowns		
650	Crown, plastic (laboratory processed)	150.00
651	Crown, plastic with metal	220.00
652	Crown, porcelain	375.00
653	Crown, porcelain fused to metal	340.00
660	Crown, cast, full	340.00
663	Crown, cast, three quarters	375.00
670	Crown, stainless steel. primary	75.00
671	Crown, stainless steel, permanent	90.00
672	Gold dowel post	75.00
Prosthetics (680-799)		
Pontics		
680	Fixed bridge pontic, cast metal	325.00
681	Fixed bridge pontic, slotted facing	325.00
682	Fixed bridge pontic, slotted pontic	325.00
692	Fixed bridge pontic, porcelain fused to metal	325.00
693	Fixed bridge pontic, plastic processed to metal	325.00
Recementation		
685	Recement inlay, facing, pontic	30.00
686	Recement crown	30.00
687	Recement bridge	50.00
Repairs, Crown, and Bridge		
690	Repair fixed bridge	By Report
694	Replace broken tru-pontic	75.00
695	Replace broken facing, post intact	75.00
696	Replace broken facing, post backing broken	75.00

Procedure Number	Procedure Description	Maximum Allowance
Removal Prosthodontics		
700	Complete maxillary denture	450.00
701	Complete mandibular denture	450.00
702	Partial upper or lower denture with two assembled wrought wire or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base	415.00
703	Partial upper or lower denture with cast chrome skeleton, two cast clasps, and necessary teeth	400.00
704	Clasp, third and each additional clasp for Procedure 703	40.00
705	Stressbreaker, extra	40.00
706	Partial upper or lower stayplate, acrylic base fee, teeth and clasps extra	150.00
708	Partial upper or lower denture, all acrylic with two assembled wrought wire clasps having two clasp arms, but no rests, and necessary teeth	275.00
709	Clasp, third and each additional for Procedure 708	25.00
712	Clasp, third and each additional for Procedure 702	25.00
716	Clasp or teeth, each for Procedure 706	23.00
720	Denture adjustment, per visit	25.00
721	Reline - office, cold cure	70.00
722	Reline - laboratory processed	140.00
723	Tissue conditioning, per denture	50.00
724	Denture duplication (“jump,” “reconstruction”), denture base including necessary tooth replacement, per denture	150.00
Repairs, Dentures, Acrylic		
750	Repair broken denture base only (complete or partial)	45.00
751	Repair broken denture base and replace one broken denture tooth (maximum two)	65.00
752	Each additional denture tooth replaced on 751 repair (maximum two)	15.00
753	Replace one broken denture tooth only (complete or partial)	50.00
754	Each additional denture tooth replaced on 753 repair (maximum two)	15.00
755	Adding first tooth to partial denture to replace newly extracted natural tooth	65.00
756	Each additional natural tooth replaced on 755 repair (maximum two)	30.00
757	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and rest to an existing 702 partial denture	75.00
758	Each additional new or replacement clasp for repair 757 (maximum two)	75.00
759	Add a new or replace broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 708 partial denture	75.00
760	Each additional new or replacement clasp for repair 759 (maximum two)	50.00

Procedure Number	Procedure Description	Maximum Allowance
761	Reattaching clasp on partial denture, clasp intact, each (maximum two)	60.00
762	Add a new or replace a broken cast chrome cobalt clasp with two clasp arms and rest to an existing 703 partial denture	75.00
763	Each additional new or replacement clasp for repair 762 (maximum two)	75.00
Space Maintainers (Procedures 800-899) (primary teeth, not age-related)		
800	Fixed, unilateral band type space maintainer; (including band)	120.00
801	Removable, plastic - with two stainless steel round wire clasps or rests	230.00
802	Each additional clap or rest (for 801 only)	15.00
811	Fixed, unilateral, stainless steel crown type space maintainer; (including crown, Procedure 670 or 671); space maintainer	111.00
812	Fixed, bilateral, lingual, or palatal bar type space maintainer	200.00
832	Fixed or removable appliance to control harmful habit	221.00
Fractures and Dislocations (*includes usual follow-up care*) (Procedures 900-949)		
900	Maxilla - open reduction, simple	1000.00
901	Maxilla - closed reduction, simple	500.00
902	Mandible - open reduction, simple	1200.00
903	Mandible - closed reduction, simple	700.00
904	Maxilla - closed reduction, compound	800.00
905	Maxilla - open reduction, compound	1200.00
906	Mandible - closed reduction, compound	800.00
907	Mandible - open reduction, compound	1200.00
913	Reduction of dislocation of temporomandibular joint	140.00
915	Treatment of malar fracture, simple, closed reduction	250.00
916	Treatment of malar fracture, simple or compound depressed, open reduction	500.00
Maxillofacial Dental Services (Procedures 950-998)		
Diagnostic Services		
950	Clinical examination and consultation, including study models	100.00
952	Prosthetic evaluation and treatment plan, including study models	100.00
955	TMJ series radiographs	100.00
956	Cephalometric head film - single, first film, including tracing	50.00
957	Cephalometric head film - each additional film, including tracing	10.00
Maxillofacial Prosthetic Services		
960	Speech appliance, transitional, with or without pharyngeal extension	800.00
962	Speech appliance, permanent, edentulous, with or without pharyngeal extension	1400.00
964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension	1500.00

Pro-cedure Number	Procedure Description	Maximum Allowance
966	Palatal lift, interim	800.00
968	Palatal lift permanent, cast framework	1400.00
970	Obturator, immediate surgical, routine	900.00
971	Obturator, immediate surgical, complex	1200.00
972	Obturator, permanent, complex	1500.00
973	Resection prosthesis, permanent, edentulous, complex	1500.00
974	Resection prosthesis, permanent, edentulous, routine	1400.00
975	Resection prosthesis, permanent, partially edentulous, complex	1700.00
976	Repositioner, mandibular, two piece	2300.00
977	Removable facial prosthesis	By Report
978	Splints and stents	By Report
979	Radiation therapy fluoride carrier	80.00
980	Repairs, maxillofacial prosthesis	By Report
981	Rebase, laboratory processed, maxillofacial prosthesis	By Report
982	Balancing (opposing) maxillofacial appliance	By Report
985	Maxillofacial surgical procedures	By Report
Temporamandibular Joint Dysfunction Management		
990	Occlusal analysis, including report and/or models	180.00
992	Occlusal adjustments, limited centric and excursive adjustments, including records and/or models	90.00
994	Occlusal balancing, altering centric relation, including records and/or models	400.00
995	Orthopedic stabilizing appliance, disocclusion splint	300.00
996	Postoperative visits, symptomatic care, and counseling	75.00
998	Unlisted therapeutic service	By Report
Unlisted Services		
999		By Report

DENTI-CAL PROCEDURE CODE CROSS REFERENCE TABLE

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
010	9010	00100
015	9015	00120
020	9020	09430
030	9030	09440
035	9035	09425
040	9040	09310
045	9045	01352
046	9046	01353
049	9049	01120
050	9050	01110
061	9061	01201
062	9062	01202
080	9080	09110
110	9110	00220
111	9111	00230
112	9112	00210
113	9113	00240
114	9114	00250
115	9115	00260
116	9116	00272
117	9117	00274
118	9118	00270
119	9119	00475
120	9120	00476
125	9125	00330
150	9150	07286
160	9160	00450
200	9200	07110
201	9201	07120
202	9202	07210
203	9203	07255
204	9204	07256
220	9220	09930
230	9230	07220
231	9231	07230
232	9232	07240
250	9250	07320
252	9252	07310
255	9255	07340
256	9256	07341
257	9257	07470
258	9258	07471
259	9259	07970
260	9260	07510
261	9261	07520
262	9262	07425
263	9263	07980

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
264	9264	07981
265	9265	07983
266	9266	07982
267	9267	07360
269	9269	07430
270	9270	07431
271	9271	07440
273	9273	07270
275	9275	07272
276	9276	07540
277	9277	07490
278	9278	07560
279	9279	07260
280	9280	07450
281	9281	07451
282	9282	07550
285	9285	07840
289	9289	07850
290	9290	07530
291	9291	07960
292	9292	07910
294	9294	07880
295	9295	07930
296	9296	07281
297	9297	07282
298	9298	07283
299	9299	07999
300	9300	09610
301	9301	09230
400	9400	09220
451	9451	04930
452	9452	04220
453	9453	04330
472	9472	04210
473	9473	04260
474	9474	04211
501	9501	03210
502	9502	03220
503	9503	03120
511	9511	03310
512	9512	03320
513	9513	03330
530	9530	03420
531	9531	03410
534	9534	03350
551	9551	70551
552	9552	08856
554	9554	08857
556	9556	08858
557	9557	70557
558	9558	70558

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
560	9560	08355
562	9562	08356
564	9564	08357
570	9570	08455
572	9572	08456
580	9580	08555
582	9582	08556
590	9590	08955
592	9592	08956
594	9594	08957
596	9596	08758
598	9598	08959
599	9599	08750
600	9600	02110
601	9601	02120
602	9602	02130
603	9603	02131
611	9611	02140
612	9612	02150
613	9613	02160
614	9614	02161
640	9640	02210
641	9641	02211
645	9645	02310
646	9646	02335
648	9648	02334
650	9650	02710
651	9651	02720
652	9652	02740
653	9653	02750
660	9660	02790
663	9663	02810
670	9670	02830
671	9671	02831
672	9672	02892
680	9680	06210
681	9681	06220
682	9682	06230
685	9685	02910
686	9686	02920
687	9687	06930
690	9690	06600
692	9692	06240
693	9693	06250
694	9694	06610
695	9695	06620
696	9696	06630
700	9700	05110
701	9701	05120
702	9702	05211
703	9703	05213

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
704	9704	05310
705	9705	06940
706	9706	05820
708	9708	05216
709	9709	05311
712	9712	05312
716	9716	05822
720	9720	05400
721	9721	05730
722	9722	05750
723	9723	05850
724	9724	05700
750	9750	05610
751	9751	05641
752	9752	05642
753	9753	05643
754	9754	05644
755	9755	05651
756	9756	05652
757	9757	05661
758	9758	05662
759	9759	05663
760	9760	05664
761	9761	05675
762	9762	05680
763	9763	05681
800	9800	01510
801	9801	01525
802	9802	01526
811	9811	01511
812	9812	01515
832	9932	01530
900	9900	07610
901	9901	07620
902	9902	07630
903	9903	07640
904	9904	07720
905	9905	07710
906	9906	07740
907	9907	07730
913	9913	07830
915	9915	07660
916	9916	07750
950	9950	00115
952	9952	00116
955	9955	00322
956	9956	00340
957	9957	00341
960	9960	05901
962	9962	05902
964	9964	05903

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
966	9966	05904
968	9968	05905
970	9970	05910
971	9971	05911
972	9972	05914
975	9975	05918
976	9976	05930
977	9977	05931
978	9978	05925
979	9979	05926
980	9980	05927
981	9981	05928
982	9982	05929
985	9985	05939
990	9990	05980
992	9992	05981
994	9994	05982
995	9995	05995
996	9996	05984
998	9998	05985
999	9999	09999